CITY OF BALTIMORE

HEALTH DEPT.

BUREAU OF

VITAL STATISTICS

DEATHS

BEGINNING 1940

KP 23907

CITY HALL
BALTIMORE 2, MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE

RECORDS MANAGEMENT DIVISION

DECLARATION OF INTENT

THE CITY RECORDS MANAGEMENT OFFICER HEREBY DECLARES THAT THE RECORDS MICROFILMED HEREIN, ARE ACTUAL RECORDS OF THE DEPARTMENT OF Health BUREAU OF Vital Statistics CREATED DURING THE NORMAL COURSE OF BUSINESS AND THAT THE MICROFILM WILL BE INSPECTED TO ASSURE COMPLETENESS OF COVERAGE, AND THAT:

THE MICROFILMING OF THE RECORDS IS ACCOMPLISHED AS PROVIDED FOR IN REQUEST FOR RETENTION PERIOD, AUTHORIZATION NO. 345 AS APPROVED BY THE RECORDS COMMITTEE IN ACCORDANCE WITH ORDINANCE NO. 1096 APPROVED BY THE MAYOR ON JUNE 4, 1954.

FORM RM-1 (11-58) RETAIN—PERM.

Authorization No. 345

REQUEST FOR RETENTION PERIOD

Department: Health

To: Records Management Officer,
Room 408, City Hall, Baltimore, 2, Md.

Bureau: Vital Statistics

Record Identification

1. TITLE:	2. Form No. if available	3. Type—(cards, paper, etc.)
Certificate of Death		Bound Book

4. Dates	5. Volume accumulated yearly	6. Size of Record	7. Number of copies made
		Misc.	One (1)

8. Authorization Requested (check only one (1) of the squares below)

A.	B.	C.	D.
☐ Establish retention period for records which are accumulating daily.	☐ Dispose of present accumulation, no additional accumulation anticipated.	☐ Microfilm and destroy originals.	☒ Microfilm and retain originals for length of time indicated below.

9. Recommended Retention Period a. In Dept.	b. In Storage Center	c. Total	10. Equipment and space freed.	11. In your opinion does this record have any historical significance?
12 yrs.	Micro. Perm.	12 yrs. and Micro. Perm.		YES ☐ NO ☒

12. DESCRIPTION OF RECORD: (describe accurately and show recommended retention period.)

These are vital records known as Certificates of Death, required by statute to be registered with the Baltimore City Health Department within several days after the occurrence.

RETENTION PERIOD REQUESTED: Microfilm all Certificates in duplicate retaining the film permanently and store the duplicate rolls of film for security purposes.

Retain original death certificates Twelve (12) years after date of registration, and then destroy after microfilming.

Department or Bureau Approval Robert E. Farber, M.D. Title: Commissioner of Health 3/28/63 Date

Recommendation of Records Management Officer

13. Recommended Retention Period a. In Dept.	b. In Storage Center	c. Total	14. Disposal Method A	B	C
12 yrs.	Microfilm Permanent	12 yrs. and Microfilm Permanent	☐ To be sold as scrap or waste paper	☒ To be Burned or shredded	☐ Historical, (to be transferred to Dept. of Legislative Reference.)

REMARKS:

C P Boyce 3/29/63
Records Management Officer Date

APPROVALS OF RECORDS DISPOSAL COMMITTEE

KINDLY RETURN TO: RECORDS MANAGEMENT OFFICER
ROOM 408, CITY HALL, BALTIMORE 2, MD.

1. APPROVED: CITY AUDITOR

2. APPROVED: CITY SOLICITOR

3. APPROVED: CITY COMPTROLLER

4. APPROVED: CITY TREASURER

5. APPROVED: DIRECTOR, DEPT. OF PUBLIC WORKS

6. APPROVED: DIRECTOR OF THE MUNICIPAL MUSEUM

7. APPROVED: DIRECTOR, DEPT. OF LEGISLATIVE REFERENCE

FILED ON FILM

IN

NUMERICAL ORDER

633610

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48 B

633610 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 333 E. 28th Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 6 Mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 333 E 28th Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mae E. Morton

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	068-05-5940

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife John H. Morton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 27 1900

8. AGE: Years	Months	Days	If less than one day
45	10	1	hr. min.

9. Birthplace Pa. (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business Beth. Fairfield

FATHER
12. Name Charles Hammers
13. Birthplace Pa.

MOTHER
14. Maiden Name Beckendorf
15. Birthplace Pa.

16 (a) Informant John H. Morton
(b) Address 333 E 28th St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10/28/45 (month) (day) (year)
(c) Cemetery or crematory
Location Avoca, Pa.

18 (a) Funeral director Wm. J. Ticknor & Sons
(b) Address North & Pa. Aves

(b) Signature for Williams, M.D. Registrar
OCT 29 1945 (Date received by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/28 1945, at 99 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1945 to Oct 26, 1945 and that I last saw he alive on 10/26 1945.

Immediate cause of death Carcinoma of uterus. — Duration 1 yr mo.
Due to Metastasis to abdominal lungs.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Willis Greytock, M. D.
Address 3963 Greenmount Ave. Date signed 10/28/45

VS 150

G33611

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92 B Registered No. G33611

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2765 Baker St.
(c) Hospital or institution:
15 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2765 Baker St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN R. THOME

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Margaret C. Thome
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 29, 1876

8. AGE: Years	Months	Days	If less than one day
69	1	27	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name John Thome
13. Birthplace Germany

MOTHER
14. Maiden Name Barbara Leist
15. Birthplace Germany

16 (a) Informant Mrs. Margaret C. Thome
(b) Address 2765 Baker St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/30/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 OCT 29 1945 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 26, 1945 at 4.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 17 1945 to Oct 26 1945 and that I last saw him alive on Oct 24 1945

Immediate cause of death	Duration
Mitral Regurgitation	5 wks.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Isaac C. Dickson. M. D.
Address 3055 N. North Ave. Date signed 10/27/45

VS 130

X

Please write plainly; ink or indelible pencil should be used. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

633612

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47D

633612 Registered No.

Please write plainly with pen or information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3543 Elmley Ave.
(c) Hospital or institution: 81

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3543 Elmley Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY JULIA WARNER

3 (b) If veteran, name war: none
3 (c) Social Security Account No. 212-10-5222

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife: Norman D. Warner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 15, 1893

8. AGE: Years	Months	Days	If less than one day
52	2	11	hr. min.

9. Birthplace: Richmond County, Va.
(Town, county, and state)
10. Usual Occupation: Operator
11. Industry or business: B. V. D. Corporation

FATHER
12. Name: Unknown
13. Birthplace: "

MOTHER
14. Maiden Name: "
15. Birthplace: "

16 (a) Informant: Mrs. James Engelbach, daughter
(b) Address: 3543 Elmley Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/29/45 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location:

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 OCT 29 1945 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 26, 1945, at 6:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1944 19 to Oct 26 1945, and that I last saw h[illegible] alive on Oct 1 1945.

Immediate cause of death: Carcinoma of lung — Duration: 1 year
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation June 1945
Major findings of operation: Widespread metastases
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature]
Address 2904 Reisterstown Rd. Date signed Nov 27 1945

VS 150

G33613

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G33613

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3306 Forest Park Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3306 Forest Park Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZABETH E. DUNN

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Joseph Dunn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 19, 1881

8. AGE: Years	Months	Days	If less than one day
63	11	6	hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Peter Steinick
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Minia Bauer
15. Birthplace Balto., Md.

16 (a) Informant Mr. Clark J. Dunn
(b) Address 3306 Forest Park Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/29/45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

OCT 29 1945 (b) Huntington Wilkinson, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 25, 1945 at 4:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 23 1945 to Oct 25 1945, and that I last saw h[illegible] alive on Oct 25 1945.

Immediate cause of death: Cerebral Hemorrhage — Duration 2 da

Due to: Hypertension — Duration ?

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph L. Blum M.D.
Address 5[illegible] E. Madison St. Date signed 10/27/45

VS 190

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

633614

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

Registered No. 633614

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette & St. John St.
(c) Hospital or institution: Hospital for the Women of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 20-2 Abell Ave. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Susan Baker Cary.

3 (b) If veteran, name war: none.
3 (c) Social Security Account No. none.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: A. Howard Cary.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-30-1866

8. AGE: Years 79 | Months 4 | Days 28 | If less than one day hr. min.

9. Birthplace Guilford County, Md. (Town, county, and state)

10. Usual Occupation None.

11. Industry or business

FATHER
12. Name Ephraim Collins
13. Birthplace Frederick County, Maryland

MOTHER
14. Maiden Name Sally Johnson
15. Birthplace Howard County, Md.

16 (a) Informant Hospital record.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/29/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address North & Pa. Aves.

OCT 29 1945 (Date received by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 27 1945 at 12 30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-1 1945 to 10-27 1945 and that I last saw h.e.r. alive on 10-24 1945.

	Duration
Immediate cause of death Generalized carcinomatosis	12 mos.
Due to Carcinoma of the ovaries	18 mos.
Due to	
Other Conditions Arteriosclerosis - general. papilloma of urethra (Include pregnancy within 3 months of death)	

Date of operation 10-4-45
Major findings of operation: Generalized carcinomatosis
of autopsy: None.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William H. Henninger M. D.
Address Womens Hospital Baltimore (17) Md. Date signed 10-29-45

633615

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. 633615

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore - #18 (If outside city or town limits, write RURAL and give town)
(d) Street No. 2105 N. Calvert St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) **FULL NAME** Mrs. Hillie R. McDonald

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widowed

6 (b) Name of husband or wife Frank McDonald
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 16- 1905

8. AGE: Years	Months	Days	If less than one day
40	7	10	hr. min.

9. Birthplace Maryland (Mt. Airey) (Town, county, and state)
10. Usual Occupation Industrial laboratories
11. Industry or business (Clerk)

FATHER
12. Name Robert Runkles
13. Birthplace Maryland

MOTHER
14. Maiden Name Jessie Leeper
15. Birthplace Iowa

16 (a) Informant Mr. Carlton L. Molesworth
(b) Address Jefferson Apt.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/29/45 (month) (day) (year)
(c) Cemetery or crematory Prospect Cem.
Location Mt. Airey, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 29 1945 (Date rec'd by registrar) (b) Funeral director's signature and address Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-26 1945, at 7:36 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-25 1945 to 10-26 1945 and that I last saw her alive on 10-26 1945

Immediate cause of death	Duration
Cerebral [redacted] Vascular Rupture	24 hrs.
Due to Hypertension	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. A. Steeden Jr M. D.
Address Mercy Hospital Date signed 10/26/45

VS 150

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G33616

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

Registered No. G33616

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 822 N. Carrollton Ave.
(c) Hospital or institution:
N. M. Carroll Home for the Aged
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 822 N. Carrollton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: VIRGINIA TAYLOR

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1855

8. AGE: Years 90 | Months | Days | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Not Known
13. Birthplace " "

MOTHER
14. Maiden Name Not Known
15. Birthplace " "

16 (a) Informant Aged Home Records
(b) Address 822 N. Carrollton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-29-45 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

OCT 29 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 25, 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 20 45 to Oct 45 19 45
and that I last saw alive on Oct 45 19 45.

Immediate cause of death
Cystomyoma of Breast — Duration 6 Months

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M.D.
Address 726 N. Charles St. Date signed 10/29/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

633617

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 633617

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5808 Pimlico Road
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Cambridge Arms Apts.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Cambridge Arms Apts.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Douglas Hall Rose

3 (b) If veteran, name war: None
3 (c) Social Security Account No. 212-16-5163

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: Single
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May-5-1863

8. AGE: Years 82. Months 5 Days 22 If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation President of
11. Industry or business Maryland Life Ins. Co.

FATHER
12. Name John Rose
13. Birthplace probably Baltimore, Md.

MOTHER
14. Maiden Name Mary Elizabeth Hall
15. Birthplace probably Baltimore, Md.

16 (a) Informant Douglas H. Rose, 2nd. (Nephew)
(b) Address 5805 Pimlico Road, City.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct-29-45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Maryland

18 (a) Funeral director Stewart & Mowen Company
(b) Address 108 W. North Avenue, City.

19 Oct 29 1945 (Date rec'd by Registrar) (b) Huntington Mills Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Night Oct 26-27 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 16 1945 to Oct 27 1945 and that I last saw him alive on Oct 25 19 45.

Immediate cause of death	Duration
Coronary artery	
Arteriosclerosis	
Due to Myocardial	11 days
Insufficiency	
Due to Chronic Art. Hypertension	
Other Conditions More than 2 Yrs.	
(Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Carroll Lockard M. D.
Address 2925 N. Charles St. Date signed Oct 29 1945

THESE WHITE LEAVES, WITH UNFADING INK, correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

VS 150

G33618

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 182a

Registered No. G33618

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp. 7-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) R. H.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1009 N. Chapel St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dorothy Stokes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/13/45

8. AGE: Years	Months	Days	If less than one day
—	3	14	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Wm. Stokes
13. Birthplace Va.

MOTHER
14. Maiden Name Edith Payne
15. Birthplace South Carolina

16 (a) Informant Edith Stokes
(b) Address 1009 N. Chapel St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/29/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A. A. County, Md.

18 (a) Funeral director Joseph B. Locke, Jr.
(b) Address 1304 N. Central Ave.

19 (a) (Date) (b) Huntington Williams, M.D. Registrar

OCT 29 1945

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 27 1945, at 10:30 AM

21. I certify that I took charge of the remains described above, held an Inspection & Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation due to bed coverings

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Oct 27 1945 7/4 A.M.
(b) Where did injury occur? 1009 N. Chapel St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Suffocated in bed.

23. Signature Robert L. Baker M.D.
Medical Examiner.
Date signed Oct. 28 1945

X

633619

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 633619

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Garrison (If outside city or town limits, write RURAL and give town)
(d) Street No. Manor ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth De Vore

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: John Thomas Devore

6 (c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) June 9, 1873

8. AGE: Years 72 | Months 4 | Days 16 | If less than one day — hr. min.

9. Birthplace Eastern Shore, Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Joseph Funk
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Wehrlet
15. Birthplace Austria

16 (a) Informant John Thomas Devore
(b) Address Garrison, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 29 45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director Frank A. Hurley
(b) Address Pikesville, Maryland

19 OCT 29 1945 (Date received by registrar) Huntington Hill (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 25, 1945, at 11:50 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bronchopneumonia

Due to

Other Conditions Coronary Sclerosis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Stefanelli M.D. Medical Examiner.
Date signed October 26, 1945.

VS 151

633620

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

633620 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6028 Old Harford Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6028 Harford Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth A. Tarleton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	widow

6 (b) Name of husband or wife Pinkney C. Tarleton

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 5, 1873

8. AGE: Years	Months	Days	If less than one day
72	7	21	hr. min.

9. Birthplace Somerset Co. Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER
12. Name George B. Mason
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Anna Scott
15. Birthplace Md.

16 (a) Informant Mrs Sadie B. Layton
(b) Address 211 Hopkins Rd.

17 (a) Burial (b) Date thereof 10/29/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location E. End of North Ave.

18 (a) Funeral director John F. Heiny Inc
(b) Address 715 Light St.

19 OCT 29 1945 Thurlington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 26th 1945, at 9 30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1945 to Oct 26 1945
and that I last saw him alive on Oct 24 1945

Immediate cause of death	Duration
Primary Pleural Carcinoma	
Due to Secondary Nodules	
Due to Peritonitis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature T. Nod Angela M. D.

Address 600 N Patterson Park Ave Date signed 10/28/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

633621

BALTIMORE CITY HEALTH DEPARTMENT X ✓ 633621

CERTIFICATE OF DEATH 937 Registered No.

633621

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town Philadelphia (If outside city or town limits, write RURAL and give town)
(d) Street No. 6612 N. 8th St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Abe H. Schloss

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Carolyn S. Schloss
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 26 1886

8. AGE: Years 59 | Months 9 | Days 1 | If less than one day hr. min.

9. Birthplace Phila. Pa. (Town, county, and state)

10. Usual Occupation Retired Salesman

11. Industry or business

FATHER
12. Name Henry Schloss
13. Birthplace Unknown

MOTHER
14. Maiden name Bessie Oppenheimer
15. Birthplace Phila. Pa.

16 (a) Informant Mrs. Carlyn S. Schloss
(b) Address Phila. Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/30/45 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friends Assn
Location Balto. Md.

18 (a) Funeral director Harris Somerstein & Son
(b) Address 1007 E. Eutaw Place

19 OCT 29 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-27-45 19 , at 11:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-24 1945 to 10-27 1945 and that I last saw him alive on 10-27 1945.

Immediate cause of death	Duration
Suppurative Mediastinitis	
Due to Unknown cause	
Due to	
Other Conditions Arteriosclerotic Heart disease (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation: Suppurative Mediastinitis
No
of autopsy: Suppurative Mediastinitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Bertha Lader M. D.
Address Sinai Hosp. Date signed 10/27/45

VS 150

114E

TYPING WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

633622

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

12B

Registered No. 633622

1. PLACE OF DEATH:
(a) Baltimore City, Maryland — D.O.A.
(b) Street address 435 Druid Hill Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 435 Druid Hill Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	married

6 (b) Name of husband or wife Elizabeth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 6, 1918

8. AGE: Years	Months	Days	If less than one day
27	-	21	hr. min.

9. Birthplace (Town, county and state)

10. Usual Occupation tap dancer

11. Industry or business

FATHER — 12. Name Frank Brown
13. Birthplace Md.

MOTHER — 14. Maiden Name Hattie Butt
15. Birthplace Va.

16 (a) Informant Hazel Jones
(b) Address 1209 Canal St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-1-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Adolphus Hailstalk
(b) Address 918 Druid Hill Ave

19 (a) NOV 9 1945 (Date received by registrar) (b) Funeral facility Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/27 1945, at 11:57 M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Tbc

Due to

Other Conditions Osteomyelitis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature E. J. Pulaski M.D.
Medical Examiner.
Date signed 10/28/45

VS 151

633623

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 168

Registered No. 633623

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hosp 11
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 704 Madison Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Crawley Cousins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 25, 1903

8. AGE: Years	Months	Days	If less than one day
42	7	-	hr. min.

9. Birthplace Virginia
(town, county, and state)

10. Usual Occupation

11. Industry or business Gas & Electric Co

FATHER
12. Name Crawley Cousins
13. Birthplace Virginia

MOTHER
14. Maiden Name Rebeka Woodens
15. Birthplace Virginia

16 (a) Informant John Cousins
(b) Address 1015 Harlem Ave

17 (a) Burial (b) Date thereof 10-29-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave

19 (a) [illegible] Huntington Wills Registrar

MEDICAL CERTIFICATION 45

20. DATE OF DEATH Oct. 25 1945, at 2 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation
due to gassing

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Oct. 25 1945 at 1:15 A.M.
(b) Where did injury occur? 401 Orchard Street. Basement adjoining
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury Cloth tied about neck

23. Signature Robert Lee Fontaine M.D.
Medical Examiner.
Date signed Oct 25 1945

VS 151

633624

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

Registered No. 633624

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1751 North Castle St
(c) Hospital or institution: 8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 79 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
6 City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1751 N Castle Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** William C Schmitt

3 (b) If veteran, name war: no
3 (c) Social Security Account No. 217-14-1764

4. Sex: male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mary Schmitt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 5 1866

8. AGE: Years 79 | Months 5 | Days 21 | If less than one day hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation Iron molder

11. Industry or business

FATHER
12. Name Adam Schmitt
13. Birthplace Balto Md

MOTHER
14. Maiden Name Unknown
15. Birthplace Balto Md

16 (a) Informant Mrs Catherine Schmitt
(b) Address 1751 N Castle St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 30, 1945 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem
Location Belair Road

18 (a) Funeral director Albert L Hilz Jr
(b) Address 1601 N Chester St

19 (a) Oct 29 1945 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH October 26 1945, at 2:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1937 to Oct. 26 1945, and that I last saw h~~im~~ alive on Oct. 26 1945.

	Duration
Immediate cause of death: Carcinomatosis metastatic	2 yrs
Due to: Carcinoma rectum	2 yrs.
Due to:	
Other Conditions: Arteriosclerotic cardio-vascular renal disease	8

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature S. A. Alessi M.D.
M. D.
Address 621 S Hanford Rd Date signed 10/29/45

X

G33625

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G33625

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1932 Light St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Lloyd Richard Brannon

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/23/45

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Franklin Square Hospital
(Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name John Allen Brannon
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Margaret Lillian Simmons
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Margaret Brannon
(b) Address 1932 Light St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School OCT 26 1945

18 (a) Funeral director Commissioner of Health
(b) Address
19 OCT 29 1945 (b) Huntington Williams M.D.
(Date rec'd by registrar) (Signature of registrar)

VS 150

F 3044

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-24 1945, at 9:50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-23 1945 to 10-24 1945, and that I last saw him alive on 10-24 1945

Immediate cause of death	Duration
Respiratory failure	1 day
Due to Prematurity - 34 weeks 2 lbs 10 oz.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(c) Means of injury

23. Signature Bobby L. Jones M. D.
Address Franklin Square Hosp. Date signed 10-24-45

Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

633626

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. 633626

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 913 S.BINNEY ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 913 S.BINNEY ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BABY GIRL FLETCHER

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. NONE

4. Sex: FEMALE

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) OCT. 25/45

8. AGE: Years 0 | Months | Days 1 | If less than one day ... hr. ... min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER
12. Name WILLIAM FLETCHER
13. Birthplace BALTO.

MOTHER
14. Maiden Name VIRGINIA BERGGER
15. Birthplace BALTO.

16 (a) Informant CHARLOTTE LARSON(GRANDMOTHER)
(b) Address 913 S.BINNEY ST.

17 (a) BURIAL (b) Date thereof OCT.29/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory MT.CARMEL.
Location ODONNELL ST.

18 (a) Funeral director Lilly & Zeiler Inc.
(b) Address 403 S.WOLFE ST.

OCT 29 1945 (b) Huntington Williams M.D.
Date received (by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH OCT. 26 1945 at 5 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Octb. 25 1945 to Octb. 26 1945 and that I last saw h.er alive on Octb. 25 1945.

Immediate cause of death: Pneumonary atelectasis — Duration: few hours

Due to: Rematurity

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation: None

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide: NONE
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature Jno. A. Rosenblatt M. D.
Address 518 O'Donnell St. Date signed 10-29-45

VS 150

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

633627

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

633627 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: 701 North Kenwood
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 527 North Wolfe (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRED BARTH

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Emma
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 11 1893

8. AGE: Years	Months	Days	If less than one day
52	7	16	hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation Street Car Conductor
11. Industry or business

FATHER
12. Name Frederick A Barth
13. Birthplace ?

MOTHER
14. Maiden Name Anna
15. Birthplace Balt Md

16 (a) Informant Emma Barth
(b) Address 527 N Wolfe St

17. Burial (Burial, cremation, or removal) (b) Date thereof 10/30/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md

18 (a) Funeral director Fallon Co Inc
(b) Address 229 N Eutaw St

19 OCT 29 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/27/45 19 , at 11:45 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to Exo death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John A Davis, M.D. Medical Examiner
Date signed 10/29/45

X

633628

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1246

Registered No. 633628

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address North Broadway
(c) Hospital or institution: The Children Home + Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days) 3 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County —
(c) City or town Baltimore - 25
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3703 St. Victor St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Vernon Triplett

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: Marian Triplett

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 2-2-1901

8. AGE: Years 44 | Months 8 | Days 26 | If less than one day ____ hr. ____ min.

9. Birthplace Lenoir, North Carolina (Town, county, and state)

10. Usual Occupation Steel Erector

11. Industry or business Ship Building.

FATHER
12. Name Thomas E. Triplett
13. Birthplace North Carolina.

MOTHER
14. Maiden Name Cornelia Campbell
15. Birthplace North Carolina.

16 (a) Informant Lloyd V. Triplett
(b) Address 3703 St. Victor St, Balto - 25.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/31/45 (month) (day) (year)
(c) Cemetery or crematory Woodland Park
Location Baltimore Co. Md.

18 (a) Funeral director Tillman Conroe
(b) Address 1210 E. Pond St.

OCT 29 1945 (Date rec'd by Registrar) (b) Huntington Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-28 1945 at 4:35 A M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-24-45 19__, to 10-28 1945. and that I last saw h.i.m. alive on 10-28 1945

Immediate cause of death HEMORRHAGE FROM G.I. TRACT - PROBABLY ESOPHAGEAL VARICES.
Due to CIRRHOSIS OF LIVER
Due to
Other Conditions SPLENOMEGALY

(Include pregnancy within 3 months of death)
Date of operation 10-26-45
Major findings of operation: CIRRHOSIS OF LIVER, SPLENOMEGALY.
of autopsy: NONE OBTAINED.

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James B. Littlefield M. D.
Address The Church Home + Hosp. Date signed 10-28-45

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Any error or information should be carefully supplied. The

VS 150

(over)

X

633629

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

633629

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1523 Gorsuch Ave DOA
(c) Hospital or institution: 91
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1523 Gorsuch Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ralph Crooks

3 (b) If veteran, name war: World #1

3 (c) Social Security Account No.: None

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Rose E

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Feb 13, 1893

8. AGE: Years: 52. Months: 8 Days: 15 If less than one day: hr. min.

9. Birthplace: Yonkers N. Y.
(Town, county, and state)

10. Usual Occupation: Gard

11. Industry or business: Md Pen

FATHER
12. Name: Thomas Crooks
13. Birthplace: Virginia

MOTHER
14. Maiden Name: Pauline Bath
15. Birthplace: Yonkers N. Y.

16 (a) Informant: Rose E Crooks
(b) Address: 1523 Gorsuch Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/29/45 (month) (day) (year)
(c) Cemetery or crematory: Oakland
Location: Yonkers N. Y.

18 (a) Funeral director: Wilson & Dove
(b) Address: 1219 St Paul St

10 OCT 29 1945 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/28 1945, at 10 00 A M

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature D. J. Polvinale M.D.
Medical Examiner.
Date signed 10/29/45

633630 ✓ 633630

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 401 N Pulaski St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V°
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 401 N Pulaski St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Frank W Harry

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Mary Frances

6 (c) If dead, give age years

7. Birth date of deceased (mo., day, yr.) 1/10/1862

8. AGE: Years	Months	Days	If less than one day
78	9	16	hr. min.

9. Birthplace Baltimore (Town, county, and State)

10. Usual Occupation Gas Fitter Co

11. Industry or business

FATHER
12. Name Thomas W Harry
13. Birthplace Ireland

MOTHER
14. Maiden Name Amanda Brown
15. Birthplace Balto Md

16 (a) Informant Lillian M Walker
(b) Address 401 N Pulaski

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/29/45 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cem
Location Frederick Rd

18 (a) Funeral director Edward Sayler
(b) Address 2309 West Blvd

19 (a) OCT 29 1945 (Date rec'd by registrar) Huntington Williams Funeral Home

MEDICAL CERTIFICATION

20. DATE OF DEATH October 26 1945, at 5:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from — 1925, to Oct 25 1945 and that I last saw h.i.m. alive on Oct 25 1945

Immediate cause of death Carcinoma of Stomach — Duration 7

Due to

Due to

Other Conditions Diabetes Mellitus, Arteriosclerosis — Duration 7 3

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work?
(e) Means of injury —

23. Signature Carey Rostring M. D.
Address 134 N Lombard St Date signed 10/27/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G33631

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

830

Registered No. G33631

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1627 W. Lexington St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1627 W. Lexington St.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Hattie Washington

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: George

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 7, 1895

8. AGE: Years 50 | Months 7 | Days 18 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Jerniah Fisher
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Louise
15. Birthplace Md.

16 (a) Informant Mrs Eva Jackson
(b) Address 1918 Druid Hill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-29-45 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location

18 (a) Funeral director Mrs Katie R. Williams

(b) Address 322 N. Schroeder St.

OCT 29 1945
(Date rec'd by registrar)

(b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 25 1945, at 7:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 20 1945 to Oct 25 1945 and that I last saw h[illegible] alive on Oct 24 1945

Immediate cause of death: Apoplexy — Duration 4 days

Due to: Arteriosclerosis

Due to: Hypertension

Other Conditions: —

(Include pregnancy within 3 months of death)

Major findings:
Of operations: —

Of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H B Huntington Williams M.D.

Address 825 N. Fremont Date signed 10/26/45

VS 3

G33632 A42649

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30F

G33632 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md., (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 113 W. Lee St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Roger Lee Stump

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-1-45

8. AGE: Years | Months: 3 | Days: 15 | If less than one day: hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Virgil Stump
13. Birthplace W. Va.

MOTHER 14. Maiden Name Leola Kuykendall
15. Birthplace Va.

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 29 1945 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Annapolis Road

18 (a) Funeral director Leo S. Crook
(b) Address 1103 N. Patterson Park Ave.

OCT 29 1945 (Date rec'd by registrar)

(b) Huntington Willis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 28 1945, at 5-45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-18- 1945, to 10-29 1945, and that I last saw h[illegible] alive on 10-29-1945.

Immediate cause of death ? Overwhelming septicaemia - Dehydration and acidosis

Due to Slough in back ? infected Dermoid

Due to

Other Conditions Diarrhea, AND and congenital lues

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M. D.
Address John Hopkins Hosp. Date signed Oct 29 45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G333633

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G333633

Registered No.

TN. 96589

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3167 Bayborian Rd. or Baybier Rd. (If rural give location)
(e) Citizen of foreign country? Denmark (Yes or No)
If yes, name country

3 (a) FULL NAME Alice Vance

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Seperated

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 6th. 1888

8. AGE: Years 57 Months 2 Days 20 If less than one day hr. min.

9. Birthplace Texas
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles King (D
13. Birthplace Texas

MOTHER
14. Maiden Name Emma McDonald
15. Birthplace Texas

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 29/45 (month) (day) (year)
(c) Cemetery or crematory Glen Haven Cem
Location Rural

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans St Huntington for Pallbearers, Md

19 Date received OCT 29 1945 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-26-45 19 45 at 3.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-10-45 19 to 10-26 19 45 and that I last saw her alive on 10-26-45 19

	Duration
Immediate cause of death cardiac failure	
Due to Hypertensive cardio-Vascular disease	
Due to	
Other Conditions Pulmonary infarction? (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jonathan Howland M. D.
Address B.C.H. Date signed 10/29/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G33634

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G33634

correct age is especially important. Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 805 South Bond Street
(c) Hospital or institution:
Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore-31,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 805 South Bond Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jozefa Dobrzykowski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband ~~or wife~~ John
6 (c) If alive, give age Deceased years

7. Birth date of deceased (mo., day, yr.) Feb, ? 1869

8. AGE: Years	Months	Days	If less than one day
76 ?	8		hr. min.

9. Birthplace Poland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Unknown SZCZEPANSKI
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Rose Dobrzykowski
(b) Address 805 South Bond Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-31-45 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Baltimore, Md.

18 (a) Funeral director George A. Weber
(b) Address 705 South Ann Street

19 (a) OCT 29 1945 (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 28th 1945, at 1.35 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/27 19 45 to 10/28 19 45, and that I last saw her alive on 10/27 19 45.

Immediate cause of death	Duration
Coronary Thrombosis	
Arteriosclerosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Martha F. Kuenkman M. D.
Address 1076 S. East Ave Date signed 10/29/45

X

G33635

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. G33635

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison + Linden
(c) Hospital or institution: Maryland General 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1225 Oakelmont Road
(If rural give location)
(e) Citizen of foreign country? a (Yes or No)
If yes, name country

3 (a) FULL NAME Lena Raine

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 22, 1867

8. AGE: Years	Months	Days	If less than one day
78	8	6	hr. min.

9. Birthplace -- (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name William Raine
13. Birthplace Germany

MOTHER
14. Maiden Name Sarah -
15. Birthplace

16 (a) Informant Mr. Charles R. Justi
(b) Address 3328 Mathieson Drive, N.E. Atlanta, Ga.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/30/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (Date received by local registrar) OCT 29 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/28 1945 at 7:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/7 1945 to 10/28 1945 and that I last saw h. alive on 10/28 1945

Immediate cause of death	Duration
Terminal Pneumonia	
Due to Cerebral Hemorrhage	21 days
Due to Hypertensive C.V. Disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Martin E. Strudel M. D.
Address Md. Gen'l Hospital Date signed 10/29/45

VS 150

X

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important. The

G33636 G33636

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48 B

Registered No.

Physicians: please write the causes of death clearly and legibly. ... accompanying coroner's inquest. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 21
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore - 16
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2910 N. Calvert St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country —

3 (a) **FULL NAME** Amelia S Beam

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced W

6 (b) Name of husband or wife Allan F. Beam

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 16 1892

8. AGE: Years 53 54 | Months 4 | Days 12 | If less than one day ... hr. ... min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Advertising

11. Industry or business Balto. News & Post

FATHER 12. Name Lewis C. Spear

13. Birthplace Maryland

MOTHER 14. Maiden Name Mary C Wright

15. Birthplace Maryland

16 (a) Informant Mrs. Ella A. March

(b) Address 1816 Poplar Grove St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/30/45 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge Cem.

Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 OCT 29 1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/28 1945 at 4/25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/09 1945 to 10/28 1945 and that I last saw her alive on 10/28 1945.

Immediate cause of death Uremia — Duration 8 days

Due to cardio renal failure — 9 days

Due to Ca of ureters extending to bladder — ?

Other Conditions ureteral trans plantation into colon

(Include pregnancy within 3 months of death)

Date of operation 10/19/44

Major findings of operation: ureters cut & bladder left hydronephrosis

of autopsy same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury

23. Signature Alex A. Tully Jr M. D.

Address Mercy Hosp. Date signed 10/28

VS 150

633637

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 162B

633637 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) all life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3017 Edmondson Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Matilda Lee Nally

3 (b) If veteran, name war —

3 (c) Social Security Account No. --

4. Sex Female

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Richard F. Nally

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-6-1861

8. AGE: Years 83 | Months 10 | Days 21 | If less than one day ... hr. ... min.

9. Birthplace Frederick Co., Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John D. Boyer
13. Birthplace Frederick Co., Md.

MOTHER
14. Maiden Name Elizabeth Brandenburg
15. Birthplace Carroll Co., Md.

16 (a) Informant Mr. Lester T. Nally
(b) Address 739 Grantley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/30/45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 29 1945 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-27 1945 at 2:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-11- 1945, to 10-27 1945, and that I last saw h.e alive on 10-27 1945

Immediate cause of death	Duration
Pneumonia	
Due to Failure	
Due to Old Age	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. H. Frye, Jr. M. D.
Address M. G. Hospital Date signed 10-29

VS 150

G33638 — BALTIMORE CITY HEALTH DEPARTMENT — G33638

CERTIFICATE OF DEATH 180

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Providence Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 540 Laurens St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Brown

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	

6 (b) Name of husband or wife James Ernest Brown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/31/1893

8. AGE: Years	Months	Days	If less than one day
49 52	4	26	hr. min.

9. Birthplace N.C. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Lee Turner
13. Birthplace N.C.

MOTHER
14. Maiden Name —
15. Birthplace

16 (a) Informant James Ernest Brown
(b) Address 540 Laurens St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/31/45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md.

18 (a) Funeral director Reg. G. Nelson
(b) Address 6303 Priestman Ave

19 (a) OCT 29 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/26 1945, at 6:45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection-Inquest Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Extensive 2nd and 3rd Degree Burns

Due to

Other Conditions Partial Carbon Monoxide Asphyxia (Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10/26/45 at about 1443 6:45 A.M.
(b) Where did injury occur? 540 Laurens St
(c) Did injury occur at home, on farm, industrial place, in public place? at home While at work? No
(d) Means of injury House caught afire

23. Signature [illegible] M.D. Medical Examiner.
Date signed 10/27/45

VS 151

G33639

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 180

Registered No. G33639

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Providence Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 540 Lawrence St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William D. Brown

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/19/1929

8. AGE: Years	Months	Days	If less than one day
15	11	12	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name James Ernest Brown
13. Birthplace Md

MOTHER 14. Maiden Name Elizabeth Turner
15. Birthplace N.C.

16 (a) Informant ~~Geo H~~ James E. Brown
(b) Address 540 Laurens St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/31/45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md.

18 (a) Funeral director Geo. U. Kelson
(b) Address 1303 Presstman St

19 (a) OCT 29 1945 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/26 1945, at 1:57 P.M.

21. I certify that I took charge of the remains described above, held an Inspection: Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death, in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Extensive 2nd and 3rd Degree Burns

Due to

Other Conditions Partial Carbon Monoxide Asphyxia
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10/26/45 about 2:15 P.M.
(b) Where did injury occur? 540 Laurens St
(c) Did injury occur at home, on farm, industrial place, in public place? at home While at work? No
(d) Means of injury Flame caught afire

23. Signature H. Leibling M.D.
Medical Examiner.
Date signed 10/29/45

VS 151

G33640 BALTIMORE CITY HEALTH DEPARTMENT G33640

CERTIFICATE OF DEATH 1702 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and name town)
(d) Street No. 1100 Woodyear street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Allen

3 (b) If veteran, name war: None

3 (c) Social Security Account No. None

Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife: None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/8/1929

8. AGE: Years 16 | Months 3 | Days 17 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Allen
13. Birthplace Md.

MOTHER
14. Maiden Name Hazel Stewart
15. Birthplace Md.

16 (a) Informant Hazel Stewart Allen
(b) Address 1100 Woodyear St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/30/45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md.

18 (a) Funeral director George G. Kelson
(b) Address 1303 Presstman St.

19 (a) OCT 29 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 25, 1945, at 6:15 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Fractured skull.
Laceration of Brain.
Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 76/2
(a) Date of injury 10-25-45 at 4:15 P. M.
(b) Where did injury occur? Riggs Ave. + Whitelock St
(c) Did injury occur at home, on farm, industrial place, in public place? Public. While at work? Yes.
(d) Means of injury fell from side of truck and rear wheels ran over head.

23. Signature Benedict Sbarretti M.D. Medical Examiner.
Date signed October 26, 1945.

VS 151

633641

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

Registered No. 633641

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2207 Orem Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 22yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2207 Orem Aven
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sam Gallin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Minnie Gallin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1894

8. AGE: Years	Months	Days	If less than one day
51			hr. min.

9. Birthplace Russia
(Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business

FATHER
12. Name Max Gallin
13. Birthplace Russia

MOTHER
14. Maiden Name Gittel-
15. Birthplace Russia

16 (a) Informant Minnie Gallin
(b) Address 2207 Orem Ave

17 (a) Burial (b) Date thereof 10-29-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Rerung Rem
Location

18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E. Balto. St

19 (a) Date filed OCT 29 1945 (b) Registrar Washington for Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-29-45 19 , at 10.45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/28 1945 to 10/28 1945 and that I last saw h[illegible] alive on 10/28 1945

Immediate cause of death Coronary thrombosis — Duration 1 day.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Harry Bolkman M.D.
Address 1921 W North Ave Date signed 10/30/45

VS 150

correct age is especially important. Physicians; please write the causes of death clearly and legibly.

63306

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

Registered No. 63042

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3022 Harford Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3022 Harford Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Richard H Davis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years 61 | Months | Days | If less than one day hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation Insurance Salesman

11. Industry or business

FATHER
12. Name Bernhardt
13. Birthplace Germany

MOTHER
14. Maiden Name Betty
15. Birthplace Germany

16 (a) Informant Mary Davis
(b) Address 3022 Harford Road

17 (a) Burial (b) Date thereof 10 30 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto. Hebrew
Location Belair Rd

18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E. Balto. St

19 (a) OCT 29 1945 (b) Huntington Williams M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/29/45 19 , at 1 A.M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertension Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John P. Davis M.D.
Medical Examiner.
Date signed 10/29/45

VS 151

G33643 THERESA M. MOORE G33643

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1220

Registered No.

Please write the causes of death clearly and legibly. Physicians; please write the causes of death clearly and legibly. Physicians; please write the causes of death clearly and legibly. Physicians;

336 44

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G336 44 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Green + Redwood Sts.
(c) Hospital or institution: University Hosp. 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4015 Roland Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Harry C. Scott

3 (b) If veteran, name war —

3 (c) Social Security Account No. 213-09-6967

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Anna Parsons Scott

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 2-1874

8. AGE: Years	Months	Days	If less than one day
71	1	25	hr. min.

9. Birthplace Bloomsbury, N.J.
(Town, county, and state)

10. Usual Occupation Retired
11. Industry or business Salesman

FATHER
12. Name Hugh B. Scott
13. Birthplace Scotland

MOTHER
14. Maiden Name Mary Smythe
15. Birthplace New York

16 (a) Informant Miss Sarah Elizabeth Scott
(b) Address 4915 Roland Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 30-1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Maryland

18 (a) Funeral director Duvall Funeral Home
(b) Address 3691 Falls Road

19 OCT 29 1945 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 27 1945, at 3 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 26 1945 to Oct. 27 1945 and that I last saw him alive on Oct. 27 1945

Immediate cause of death	Duration
Pulmonary Edema	
Due to Cerebro-Vascular Accident	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thos. R. Boone, Jr. M. D.
Address University Hosp. Date signed 10-27-45

VS 150

G33645

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 H

Registered No. G33645

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline & Oliver Sts.
(c) Hospital or institution:
St. Joseph's Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2420 E. Hoffman St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mrs. Christine Albrecht.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Late Henry C. Albrecht

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 2/6/86

8. AGE: Years 59 | Months 9 | Days 21 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business Hospital work

FATHER
12. Name Henry J. Weber
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Anna M. Bunke.
15. Birthplace Balto. Co. Md.

16 (a) Informant Mother Annie Weber
(b) Address Glenmore Ave Balto Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb 20-45 (month) (day) (year)
(c) Cemetery or crematory Balto.
Location Balto. Md.

18 (a) Funeral director Geo. L. Berger Jr
(b) Address 1512 Hollins St

19 (a) (Date rec'd by registrar) Huntington Williams

Form 29 11-43

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/27 1945, at 6:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/19 1945, to 10/27 1945 and that I last saw h.e.r. alive on 10/27 1945.

Immediate cause of death	Duration
Cardio-Respiratory Failure	
Due to Generalized Carcinomatosis	
Due to	
Other Conditions	

Biopsy - Metastatic Adenocarcinoma
(Include pregnancy within 3 months of death)

Date of operation 10/19/45

Major findings of operation: Ventral Hernia - Ca of Hernia & Mesentery

of autopsy: None.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Johnson T. Everett M. D.
Address St. Joseph's Date signed 10/27/45

EVERETT

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G33646

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55B

Registered No. G33646

Please write the cause of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 501 N. Washington St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No 501 N. Washington St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ABRAHAM PRIBESH - PRIBESH

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex MALE | 5. Color or race WHITE | 6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife MINNIE

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1888

8. AGE: Years 57 | Months | Days | If less than one day hr. min.

9. Birthplace RUSSIA (Town, county, and state)

10. Usual Occupation CANFECTIONERY STORE

11. Industry or business

FATHER
12. Name BENJ. PRIBESH
13. Birthplace RUSSIA

MOTHER
14. Maiden Name BEATRICE
15. Birthplace RUSSIA

16 (a) Informant WIFE
(b) Address

17 (a) BURIAL (b) Date thereof 10-29-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory MT. CARMEL
Location OLD GERMAN HILL RD

18 (a) Funeral director JACK LEWIS INC
(b) Address 1439 E. BALTO. ST

19 (a) 10-29-1945 (b) Huntington Williams M.D.
(Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-28-45 19 at 10 30 M

21. I certify that death occurred on the date above stated, that I attended deceased from March 1945 to Oct 1945 and that I last saw him alive on Oct 28 1945.

	Duration
Immediate cause of death Sarcoma of pelvis & Radical Disease	
Due to Metastasis	
Due to Generalized Anemia and cachexia	Anemia Cachexia
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harris P. Dodd M. D.
Address 118 Rialto Date signed 10/29/45

X

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

G33647

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 61

G33647 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 442 N. Linwood Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 442 N. Linwood Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Kehoe

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Edward
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 15, 1885

8. AGE: Years	Months	Days	If less than one day
60	9	12	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Own Home

FATHER
12. Name Hohn Bertrand
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Maree
15. Birthplace Maryland

16 (a) Informant Mrs. Daniel Caflin
(b) Address 442 N. Linwood Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 31, 1945 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Maryland

18 (a) Funeral director William Cook, Inc.,
(b) Address 1217 St. Paul Street

19 (a) OCT 29 1945 (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 27 1945, at 10:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 24 19 45 to Oct 27 19 45 and that I last saw h M alive on Oct 27 19 45

Immediate cause of death Acute Cardiac Dec.

Duration 1 hr 2 Days 1 Wk. Yrs.

Due to Chr. Valv. Mitral Dis.

Due to Bronchial Asthma

Other Conditions Diabetes Mel.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature
Address 1500 E 3rd Date signed 10/29/45 M. D.

Hunting for Williams, M.D.

92D

VS 150

G33648

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G33648

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 503 Arson Ave (25)
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Baltimore Md
(b) City or town 503 Arson St (25)
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Alta Pauline Robinson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 3-1926

8. AGE: Years 19 | Months 10 | Days 24 | If less than one day hr. 1 min.

9. Birthplace West Virginia (Town, county, and state)

10. Usual Occupation — at Home

11. Industry or business none

FATHER
12. Name Egga D. Robinson
13. Birthplace Phillipi West Va

MOTHER
14. Maiden Name Marie Booth
15. Birthplace West Virginia

16 (a) Informant Mr E. D. Robinson
(b) Address 503 Arson Ave (25)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 31-45 (month) (day) (year)
(c) Cemetery or crematory Stringtown W Va
Location West Virginia

18 (a) Funeral director Milton S Schilling
(b) Address 3914 S. Hanover St

19 (a) (Date rec'd by local registrar) (b) Huntington Williams, M.D. Address 320 Patapsco Ave Date signed 10/31/45

OCT 29 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH October 27 1945, at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 15 1945, to Oct 27 1945, and that I last saw her alive on Oct 27 1945

Immediate cause of death Bi-lateral Pneumonia — Duration 10 days

Due to

Due to

Other Conditions Congenital Cerebral Malformations

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Paul Luben M. D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G33649

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

Registered No. G33649

Please write the causes of death clearly and legibly. Physicians: please write correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1208 Poplar Hill road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County ---
(c) City or town Mt. Washington
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1208 Poplar Hill road
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH M. REILLY

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Married

6 (b) Name of husband or wife Mary T. Reilly
6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) Apr. 30, 1880

8. AGE: Years	Months	Days	If less than one day
65	5	27	..... hr. ..... min.

9. Birthplace Mt. Washington, Md.
(Town, county, and state)
10. Usual Occupation Retired Machinist
11. Industry or business

FATHER
12. Name James T. Reilly
13. Birthplace Maryland

MOTHER
14. Maiden Name Annie Bailey
15. Birthplace Maryland

16 (a) Informant Mrs. Mary Theresa Reilly
(b) Address 1208 Poplar Hill road

17 (a) Burial (b) Date thereof Oct. 30/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Joseph's
Location Texas, Maryland

18 (a) Funeral director Clay D. Evans Son
(b) Address 118 W. Mt. Royal Ave.

OCT 29 1945 (b) Harrington Williams M.D.
(Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 27 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1945 to Oct 27 1945.
and that I last saw him alive on Oct 26 1945.

Immediate cause of death	Duration
Coronary Thrombosis	2 weeks
Due to Atherosclerotic CVD & Hypertension	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Lawrence J. Shumaker M.D.
Address 37 N. Dallas Rd. Date signed 10-29-45

VS 180

G33650

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47D

G33650 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write age is especially important. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2215 E. Preston Street
(c) Hospital or institution: 8

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County City
(c) City or town Baltimore 4
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2215 E. Preston Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William Wessell

3 (b) If veteran, name war: None
3 (c) Social Security Account No.:

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife:
6 (c) If alive, give age ——— years

7. Birth date of deceased (mo., day, yr.) June 22, 1876

8. AGE: Years 69 | Months 4 | Days 6 | If less than one day ###### hrs. ###### min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Watchman
11. Industry or business Balto; City

FATHER
12. Name Louis Wessell
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Louisa ?
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Dora Johnson
(b) Address 2215 E. Preston Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/31/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd. Balto: Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

(d) OCT 29 1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 28 1945, at ——— M

21. I certify that death occurred on the date above stated; that I attended deceased from July 30 1945, to Oct 28 1945, and that I last saw h alive on Oct 27 1945

	Duration
Immediate cause of death: Carcinoma of Lung	3 mos
Due to:	
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph Pokorny M. D.
Address 2206 E Madison St Date signed 10 29 45

X

633651

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 633651

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland Ave
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos. 8 days.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 150 N. Haven Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Snyder (Roselee Snyder)

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 218-22-4105

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Henry F. Snyder

6 (c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) Dec. 10th., 1908

8. AGE: Years 36 | Months 10 | Days 19 | If less than one day ## hr. ##### min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Packer

11. Industry or business Soft Drink Mfg.

FATHER
12. Name John Adam Sparr
13. Birthplace Philadelphia Pa.

MOTHER
14. Maiden Name Sarah E. Stewart
15. Birthplace Baltimore, Md.

16 (a) Informant Henry Frederick Snyder
(b) Address 150 N. Haven Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/31/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location E. North Avenue

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue Washington Matthews, Mgr.

19 (a) OCT 29 1945 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-27-45 19 , at 8:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 19 1945, to Oct 27 1945, and that I last saw her alive on Oct 27 1945

Immediate cause of death Carcinomatosis of Bone — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Bertha Rader M. D.
Address Sinai Hosp. Date signed 10/27

X

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G33652

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1939

Registered No. G33652

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Md.
(c) Hospital or institution Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) d.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 227 N. Bond Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cora A. Wells

3 (b) If veteran, name war —

3 (c) Social Security Account No. None

4 Sex Female | 5 Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Died Feb 5 1944

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 14, 1877

8. AGE: Years 68 | Months 1 | Days 14 | If less than one day hr. min.

9. Birthplace Crisfield, Maryland
(Town, county, and state)

10. Usual Occupation Home Worker

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Bernadette Quark
(b) Address 1257 Largent Pl.

17 (a) Burial (b) Date thereof 10 31 45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory New National
Location Frederick Rd

18 (a) Funeral director Ambrose Inc
(b) Address 444 N. Franklintown Rd

19 Date received by Registrar OCT 29 1945 (b) Huntington Williams, MD

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 28, 1945 at 2 P. M

21. I certify that I took charge of the remains described above, held an Inspection & Enquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

24. Signature Benedict Skeratelis M.D.
Medical Examiner.
Date signed October 29, 1945.

G33653 BALTIMORE CITY HEALTH DEPARTMENT G33653
CERTIFICATE OF DEATH 10
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sydenham Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7305 Hughes Ave. Jones creek
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Carol Ann Murray

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/9/42

8. AGE: Years	Months	Days	If less than one day
3	0	19	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation child
11. Industry or business

FATHER
12. Name Lester Murray
13. Birthplace Washington, Penna.

MOTHER
14. Maiden Name Marie Winbor
15. Birthplace Baltimore

16 (a) Informant Mrs. Lester Murray
(b) Address 7305 Hughes Ave. Balt. Jones creek

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-30-45 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave
18 (a) Funeral director John D. Miller Funeral Home
(b) Address 243 S. Oldtown St
19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS OCT 29 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/28/45 19..., at 6:23 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 27 1945 to Oct. 28 1945, and that I last saw her alive on Oct. 28 1945.

	Duration
Immediate cause of death Circulatory Collapse.	12 hrs.
Due to Laryngo-Tracheal + faucial Diphtheria.	2 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation Tracheotomy 10-27-45
Major findings of operation:
of autopsy: ✓

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Herman A. Bailey Jr.
Address Sydenham Hosp. Date signed 10/29/45
Margaret H.D. Smith, M.D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

633654

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

633654 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 303 S. Fremont Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 303 S. Fremont Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leroy Bullock

3 (b) If vetefan, name war

3 (c) Social Security Account No. 718-01-4800

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 1, 1901

8. AGE: Years	Months	Days	If less than one day
44	1	26	hr. min.

9. Birthplace ~~N. S.~~ S. C.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Walter Bullock
13. Birthplace ~~N. S.~~ S. C.

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs. Martha W. Green
(b) Address 303 S. Fremont Ave.

17 (a) Burial (b) Date thereof 10-30-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) Date received by registrar OCT 29 1945 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 27, 1945, at 12:10 P

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 22 1945, to Oct 27 1945, and that I last saw h[illegible] alive on Oct 27 1945.

Immediate cause of death acute Lobar Pneumonia — Duration 5 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 10/29/45

X

633655

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 137a

Registered No. 633655

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 So Light St.
(c) Hospital or institution:
So. Balto. Gen Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 618 S. Charles St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country (KROWCHUK)

3 (a) FULL NAME Demofey Krovchook - Timofhey Krowchuk

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Not known

8. AGE: Years 57? | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Not known
13. Birthplace Russian

MOTHER
14. Maiden Name Not known
15. Birthplace Russian

16 (a) Informant John A. Grebiauckas
(b) Address 423 S. Paca St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct - 30 - 45 (month) (day) (year)

(c) Cemetery or crematory Holy Trinity Russian
Location Locust Point Md

18 (a) Funeral director John A. Grebiauckas Jr.
(b) Address 423 S. Paca St

19 (a) OCT 29 1945 (Date rec'd by registrar) Huntington Wil Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 29 1945, at 12 50 a M

21. I certify that death occurred on the date above stated; that I attended deceased from [illegible] 1945 to 10/29 1945 and that I last saw him alive on 10/28 1945

Immediate cause of death Lobar Pneumonia — Duration 6 days

Due to

Due to

Other Conditions Benign Prostatic Hypertrophy

(Include pregnancy within 3 months of death)

Date of operation 10/22/1945

Major findings of operation: Ben. Prostatic Hypertrophy

of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John Mahan Bey M. D.

Address [illegible] Date signed

Gen. Hosp 10/28/1945

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G33656

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1927

Registered No. G33656

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) d.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2832 Dillon Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William J. Siegmund

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-05-5579

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Separated

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1908

8. AGE: Years	Months	Days	If less than one day
37			hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Labor

11. Industry or business

FATHER
12. Name James Siegmund
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Martha Walkowiak
15. Birthplace Baltimore Md.

16 (a) Informant Martha Siegmund
(b) Address 2832 Dillon St.

17 (a) Burial (b) Date thereof 10/30/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Dundalk Ave

18 (a) Funeral director John J. Duda
(b) Address 2829 Hudson St

19 (a) (Date received by Registrar) OCT 29 1945 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 26, 1945 at 6 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic valvular Endocarditis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Edmund Lee Easton M.D.
Medical Examiner.
Date signed October 27, 1945.

VS 151

CERTIFICATE CORRECTED 7-12-54

BALTIMORE CITY HEALTH DEPARTMENT

633657

CERTIFICATE OF DEATH

Registered No. 186a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Baltimore City Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 615 S. Rose ST.
(If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME Adam B Kendzejeski

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 21, 1910

8. AGE: Years	Months	Days	If less than one day
34	10	6	....hr. ....min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Plumbers Helper
11. Industry or business

FATHER
12. Name Frank Kendzejeski
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Tillie Golombieska
15. Birthplace Baltimore Md.

16 (a) Informant Mary Kendzejeski
(b) Address 615 N Rose St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/31/45 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart Cem
Location German Hill Rd.

18 (a) Funeral director John J. Duda
(b) Address 2829 Hudson St.

19 (a) (Date rec'd by registrar) OCT 29 1945 (b) Registrar Huntington Williams, M.D

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 27 1945, at 12 Noon M

21. I certify that I took charge of the remains described above, held an Inquest & Autopsy thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Skull

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Oct. 27 1945 2/1 10 A.M.
(b) Where did injury occur? 2020 Bank St
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? yes
(d) Means of injury Fall from roof

23. Signature Robert L. Graham M.D. Medical Examiner.
Date signed Oct. 28 1945

VS 151

X

G33658

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G33658 1148B

Registered No. G33658

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eaton & Wilkens
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1211 Maiden Choice Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Co Slacum SLACUM 35196

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Gerard H.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 22-1906

8. AGE: Years 39 | Months 8 | Days 6 | If less than one day hr. min.

9. Birthplace Baltimore - Md.
(Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name David V. O'Sullivan
13. Birthplace Md.

MOTHER
14. Maiden Name Julia A. Reardon
15. Birthplace Md.

16 (a) Informant Mrs. Gerard H. Slacum
(b) Address 1211 Maiden Choice Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-31-45 (month) (day) (year)

(c) Cemetery or crematory Mem-Cathedral
Location Balto.

18 (a) Funeral director Leonard J. Keuck
(b) Address 5305 Harford Rd.

19 (a) (Date of death registered) OCT 29 1945 (b) (Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/28 1945 at 8:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/19 1945 to 10/28 1945 and that I last saw him alive on 10/28 1945.

Immediate cause of death Acute Cardiac failure

Due to R.V. Heart Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 10/26/45

Major findings of operation Cardiac Insufficiency Grade IV Pre-Eclampsia

of autopsy:

Duration
over

PHYSICIAN
Underline the name to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. H. D'Elia M.D.
Address St Agnes Hosp Date signed 10/28/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G33659 G33659

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Meney Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 6 mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Dundalk 22 md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1902 Tolsan Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Phyllis Jane Manville (NORVELL)
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F. | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Infant

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/1944

8. AGE: Years | Months 11 | Days | If less than one day hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Wilbur Manville
13. Birthplace Va

MOTHER
14. Maiden Name Eleanor Broughman
15. Birthplace Va.

16 (a) Informant Wilbur Manville
(b) Address 1902 Tolsan Ave. Dundalk

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/28/45 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart of Mary
Location Fernhill Rd.

18 (a) Funeral director John H Connelly
(b) Address 4th & Eastern Ave. East 2la

19 (a) OCT 29 1945 Lexington Williams, Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/26/45 19 , at 5:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/26 1945, to 10/26 1945, and that I last saw her alive on 10/26 1945.

Immediate cause of death Acute Septicemia (Meningococcal) Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C H Bailey M.D.
Address Meney Date signed 10/26/45

VS 150

G33660

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 163M

G33660 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Gen'l Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D. O. A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 916 Williams ST
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Herbert Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Margaret A. Brown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 15. 1898

8. AGE: Years	Months	Days	If less than one day
47	6	12	hr. min.

9. Birthplace New Orleans La.
(Town, county, and state)

10. Usual Occupation
11. Industry or business Lloyd L. Martin

FATHER
12. Name Joseph Brown
13. Birthplace Canada

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Margaret A. Brown (wife)
(b) Address 916 Williams St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 30-1945 (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location Baltimore Co. Md.

18 (a) Funeral director Thorne & Fleming
(b) Address 1426 Light St.

19 (a) (Date rec'd by registrar) (b) Registrar

OCT 31 29 1945 Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 27 1945, at 7 P M

21. I certify that I took charge of the remains described above, held an Examination & Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation due
(a) Carbon Monoxide

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Oct. 27 1945 ? M.
(b) Where did injury occur? 400 Block Grindall ST
(c) Did injury occur at home, on farm, industrial place, in public place? Garage While at work? No
(d) Means of injury Escaped from auto

23. Signature Robert L. Traitz M.D.
Medical Examiner.
Date signed Oct 28 1945

G33661

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √61

G33661

Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Use typewriter if available. Do not write in shaded areas. Necessary supplies.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2229½ E. Baltimore
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Francis Hecker

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	Married

6 (b) Name of husband or wife Marty
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-1-02

8. AGE: Years	Months	Days	If less than one day
43	7	28	hr. min.

9. Birthplace N. Y. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Samuel Blum
13. Birthplace ?

MOTHER
14. Maiden Name Rose Schneider
15. Birthplace ?

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (b) Date thereof 10-29-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location New York

18 (a) Funeral director Jack Lewis Inc
(b) Address 459 E Balto St

19 (a) (Signature by registrar) Huntington Williams, M.D. Registrar

OCT 29 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 29 1945 10 50 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 18 1945 to Oct 29 1945 and that I last saw h M alive on Oct 29 1945.

Immediate cause of death	Duration
(a) Cardiac failure	15 d
Due to (b) myocardial insufficiency	
Due to (c) arteriosclerotic coronary thrombosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Edw Vance M.D.
Address Johns Hopkins Hospital Date signed 10/29/45

94a

G33662

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G33662
Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 331 Maydell Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give county)
(d) Street No. 331 Maydell Rd (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur H McCrea

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Widower

6 (b) Name of husband or wife Luella M
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 15 1863

8. AGE: Years	Months	Days	If less than one day
82	1	12	hr. min.

9. Birthplace Maryland (town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Wm J McCrea
13. Birthplace Md

MOTHER
14. Maiden Name Eliza Constable
15. Birthplace Md

16 (a) Informant Mrs Theodore Nengel
(b) Address 331 Maydell Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-30-45 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore Md

18 (a) Funeral director Gorsuch & Shirley
(b) Address Fulton & Fayette

19 (a) 10-29-1945 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/27 1945 at 5:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/20 1945 to 10/27 1945 and that I last saw h[illegible] alive on 10/26 1945

Immediate cause of death	Duration
Chronic Myocarditis	
Due to	
Due to	
Other Conditions Senility	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Alpha H. Demuth M. D.
Address 409 Stud Ave Date signed 10/29/45

633663

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94Q

Registered No. 633663

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 501 N. Dennison St
(c) Hospital or institution: 20

(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 501 N. Dennison St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Montgomery Sprowls

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Emma G.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 7 1907

8. AGE: Years	Months	Days	If less than one day
37	10	17/21	hr. min.

9. Birthplace Washington Tom Penna
(Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business

FATHER
12. Name Frank Sprowls
13. Birthplace Penna

MOTHER
14. Maiden Name Lydia McDaniels
15. Birthplace Penna

16 (a) Informant Mrs Emma Sprowls
(b) Address 501 Dennison st

17 (a) Removal (b) Date thereof 10-30-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Washington Tom Pa.

18 (a) Funeral director George A Farley
(b) Address Fulton & Lafayette

19 (a) OCT 29 1945 Washington Williams, Md.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/28 1945, at 1:15 P M

21. I certify that I took charge of the remains described above, held an Inspection-Inquest thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. P. Gabrielson M.D.
Medical Examiner.
Date signed 10/30/45

633654

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 475

633654
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
U.S. Marine Hospital, Balto, Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 129
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Texas (b) County
(c) City or town Freeport
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME
Bradberry, Edward

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 10, 1889

8. AGE: Years 56 | Months 3 | Days 17 | If less than one day hr. min.

9. Birthplace Plaucheville, La. (Town, county, and state)

10. Usual Occupation CG Service

11. Industry or business

FATHER
12. Name Taylor Bradberry
13. Birthplace Plaucheville, La.

MOTHER
14. Maiden Name Josephine Casaborn
15. Birthplace Plaucheville, La.

16 (a) Informant Records
(b) Address US Marine Hospital, Balto, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 29-1945 (month) (day) (year)
(c) Cemetery or crematory
Location Grand Isle Louisiana

18 (a) Funeral director Patt C. B.M. Watson
(b) Address Pratt Stricker Sts

19 OCT 30 1945 (Date received by Local Registrar) (b) Huntington Williams Registrar

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 27 1945, at 3:15A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 20 1945, to Oct. 27 1945, and that I last saw him alive on Oct. 27 1945.

	Duration
Immediate cause of death Adenocarcinoma of right lung with metastasis to pleura, epicardium and peri-	?
Due to toneum.	
Due to	
Other Conditions Bronchiectasis right lung. (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address Clinical Director Date signed 10/29/45
U.S. Marine Hospital, Balto, Md.

G33665

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50 ✓

G33665

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 835 Woodward Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 835 Woodward Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME KATHERINE H. SLOFFER

3 (b) If veteran, name war	3 (c) Social Security Account No.
N/A	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife William W. Sloffer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 17, 1883

8. AGE: Years	Months	Days	If less than one day
62	5	10	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name William Vollers
13. Birthplace Germany

MOTHER
14. Maiden Name Lotta Tiemeyer
15. Birthplace Baltimore, Maryland

16 (a) Informant William Sloffer
(b) Address 835 Woodward Street

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 10/30/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Maryland

18 (a) Funeral director WILLIAM COOK, INC.
(b) Address 1217 St. Paul Street

19 OCT 30 1945 Huntington Williams M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 27th 1945 at 3.40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 1st 1945 to Oct 27 1945 and that I last saw h[illegible] alive on Oct. 27th 1945

Immediate cause of death	Duration
Carcinoma of Breast	1 year
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry Gates M.D.
Address 517 Scott St. Date signed 10/27/45

VS 150

633866 BALTIMORE CITY HEALTH DEPARTMENT 633866

CERTIFICATE OF DEATH 170 C

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution South Baltimore Gen'l Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D. O. A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Ft. Meade
(If outside city or town limits, write RURAL and give town)
(d) Street No. Ridge Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Donald S. Foley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 29, 1935

8. AGE: Years 9 | Months 11 | Days 27 | If less than one day ..... hr. ..... min.

9. Birthplace North Carolina
(Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name Grover E. Foley.
13. Birthplace Va.

MOTHER
14. Maiden Name Elizabeth A. Pratt.
15. Birthplace North Carolina

16 (a) Informant Grover E. Foley.
(b) Address Ridge Road. Ft. Meade. Md.

17 (a) Burial. (b) Date thereof 10/30/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Meadow Ridge Memorial Park
Location Washington Blvd and Dorsey Road.

18 (a) Funeral director Howard N. Bligh Jr
(b) Address 4914 Belair Road.

19 (a) (Date received by local registrar) OCT 30 1945 Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 27, 1945, at 9:30 A. M.

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 10-27-45 at 10:15 A. M.

(b) Where did injury occur? Stoney Run Rd. Ft. Meade Q-M-Gr.

(c) Did injury occur at home, on farm, industrial place, in public place? Public. While at work? No.

(d) Means of injury: Boy struck by automobile which was thrown to the ground while riding in motor vehicle which was struck

23. Signature Howard N. Bligh M.D.
Medical Examiner.

Date signed October 27, 1945.

X

6.5006?

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

633667 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Edwood & Green St.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 64 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5602 Fair Oaks Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Salvatore Muffoletto

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of ~~husband~~ or wife Concetta Muffoletto
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 27 1879

8. AGE: Years	Months	Days	If less than one day
68	5	2	hr. min.

9. Birthplace Cefalu Italy
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Salvatore Muffoletto
13. Birthplace Italy

MOTHER
14. Maiden Name Rosa ?
15. Birthplace Italy

16 (a) Informant Concetta Muffoletto (Wife)
(b) Address 5602 Fair Oaks Ave

17 (a) Burial (b) Date thereof November 1st/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.
18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Morley St.
19 (d) OCT 30 1945
(Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 29 1945, at 5 15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 22 1945 to Oct. 29 1945 and that I last saw h~~im~~ alive on Oct. 29 1945.

Immediate cause of death	Duration
Meningitis, Diplococcus Pneumoniae Type 3.	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Reece R. Boone, Jr. M. D.
Address Univ. Hosp. Date signed 10-29-45

VS 150

G33668 **HEALTH DEPARTMENT—CITY OF BALTIMORE** G33668

CERTIFICATE OF DEATH 108

1. PLACE OF DEATH

CITY OF BALTIMORE: (No.) Centers of Mercies Hosp St., 4 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. 9 ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Jeanie Richards

If U. S. Veteran specify WAR

(a) Residence: No. 3824 Leadenhall St. St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
F	W.	S.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, year) 19 Oct 45

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
		9	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Baltimore Md

FATHER

13. NAME Joseph Richards

14. BIRTHPLACE (city or town) (State or country) Schuylkill Co Pa.

MOTHER

15. MAIDEN NAME Anna Psyche

16. BIRTHPLACE (city or town) (State or country) Schuylkill Co Pa.

17. INFORMANT Mother

(Address)

18. BURIAL, CREMATION, OR REMOVAL Place University Medical School Date OCT 29 1945

19. UNDERTAKER Commissioner of Health

(Address)

20. OCT 30 1945 Thurston Williams M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) 28 Oct 1945

22. I HEREBY CERTIFY, That I attended Deceased from 11 Oct 1945 to 28 Oct 1945

I last saw h[illegible] alive on 28 Oct 1945 Death is said to have occurred on the date stated above, at 930 P m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Pt dobar Pneumonia	17 Oct
Other contributory causes of importance:	

Was an operation performed? No Date of

For what disease or injury?

Name of operation

What test confirmed diagnosis? Clinical Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury , 19

Where did injury occur?

(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No If so, specify

(Signed) [illegible] M. D.

(Address) Vol. Centers Hosp.

OCCUPATION is very important. See instructions on back of certificate.

vb 8

3046

633669

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

633669
Registered No. [illegible]

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4016 Penhurst Ave
(c) Hospital or institution: [illegible] 15 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) [illegible]
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4016 Penhurst Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma F. Simms

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 10/29/851

8. AGE: Years 93 | Months 11 | Days 27 | If less than one day hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name John Simms
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Ann Gaston
15. Birthplace Maryland

16 (a) Informant Mrs. Thomas M. Lee Jones
(b) Address 4016 Penhurst Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/30/45 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Baltimore, Md

18 (a) Funeral director J. J. Stewart & Son
(b) Address 311 Eutaw Place

19 (a) [illegible] (b) Huntington Williams, M.D. Registrar
Entered by registrar OCT 30 1945

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/27/1945 at 5:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/20 1945 to 10/26 1945 and that I last saw h[illegible] alive on 10/26 1945

Immediate cause of death: Pulmonary Congestion — Duration: 7 days
Due to: Acute myocarditis
arterio-sclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
Signature [illegible] M.D.
Address 3902 Keswick Rd Date signed 10/29/45

G33670

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 53

✓ G33670 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 114 E Preston St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 114 E Preston St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Pierre Bonseignem

3 (b) If veteran, name war	3 (c) Social Security Account No. 212-16-9215

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Elizabeth
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 17 1871

8. AGE: Years	Months	Days	If less than one day
73	10	11	hr. min.

9. Birthplace France (Town, county, and state)
10. Usual Occupation Distiller
11. Industry or business Victor Goldsborough

FATHER
12. Name Unknown
13. Birthplace France

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Elizabeth Bonseignem
(b) Address 114 E Preston St

17 (a) Burial (b) Date thereof 10/31/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md

18 (a) Funeral director Wilhelm Bros Inc
(b) Address 217 E Fayette St

19 (a) (Date rec'd by registrar) OCT 30 1945 (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 28 1945, at 9:P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 13 1945 to Oct 28 1945; and that I last saw him alive on Oct 28 1945.

	Duration
Immediate cause of death: Cardiac Arrhest	8 hrs
Due to Coronary Occlusion	2 hrs
Due to Arteriosclerosis	2 yrs
Other Conditions	2 yrs

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide,
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Williams M.D.
Address 120 E St Paul St Date signed Oct 30/45

VS 150

33671

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

164B

Registered No. 33671

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Gen'l Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4201 Pennington Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Harold E Yeager

3 (b) If veteran, name war: World War #2
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 3, 1922

8. AGE: Years	Months	Days	If less than one day
23	6	24	hr. min.

9. Birthplace Page Co., Va. (Town, county, and state)
10. Usual Occupation Ship Fitter
11. Industry or business Bethlehem Steel

FATHER
12. Name John L Yeager
13. Birthplace Page Co, Va.

MOTHER
14. Maiden Name Minnie Bruce
15. Birthplace Rockingham Co, Va.

16 (a) Informant Mrs. John Mahn
(b) Address 1804 Bentalou St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10/31/45 (month) (day) (year)
(c) Cemetery or crematory Elkton Va
Location Elkton

18 (a) Funeral director William Cook Inc
(b) Address 1217 St Paul St

19 (a) OCT 30 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 27 1945, at 5 A M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Oct 26 1945 4 P.M.
(b) Where did injury occur? Hanover St Bridge
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? Yes
(d) Means of injury Jumped from bridge

23. Signature Robert L. Gastalter M.D. Medical Examiner.
Date signed Oct. 28 1945

933672

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170 C

Registered No. 933672

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Md.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1816 Wolfe St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Molly C. Shaw

3 (b) If veteran, name war: NV

3 (c) Social Security Account No.: none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: George H

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 23 1871

8. AGE: Years 74 | Months 9 | Days 3 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name: Wilhom T. Kenny
13. Birthplace Md

MOTHER
14. Maiden Name Sarah Fennon
15. Birthplace Md

16 (a) Informant Edward A Brown
(b) Address 566 Kovon Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/31/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Wilhom Funeral Dir
(b) Address 1204 Park Ave

OCT 30 1945 (Date rec'd by registrar) (Signature) for Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 28, 1945, at 12:05 P.M.

21. I certify that I took charge of the remains described above, held an Partial Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Intracranial hemorrhage, massive.

Due to Contusions and abrasions of forehead.

Other Conditions Fracture of nose.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-28-45 at 8:55 P.M. 26/1
(b) Where did injury occur? Belair Rd. n. of Biddle Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No.
(d) Means of injury Pedestrian struck by auto.

23. Signature Benedict Skutarelic M.D.
Medical Examiner.
Date signed October 29, 1945.

633673

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 633673

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2117 Dennison St
(c) Hospital or institution: Brantford Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 Wks
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Lutherville
(If outside city or town limits, write RURAL and give town)
(d) Street No. —
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mary Bainbridge Stone

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug ? 1865

8. AGE: Years	Months	Days	If less than one day
80	2	?	hr. min.

9. Birthplace Kentucky
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Isaac Stone
13. Birthplace Ky.

MOTHER
14. Maiden Name Sophia Bainbridge
15. Birthplace Ky.

16 (a) Informant Mrs A. Bainbridge Fonda
(b) Address Forest Md

17 (a) Burial (b) Date thereof Oct 30 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Bolto. Md

18 (a) Funeral director Henry N Jenkins Sons &
(b) Address Mt Carroll & Oakland Sts

19 (a) (Interment, cremation, or removal) (b) Registrar Williams, M.D.

OCT 30 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 29 1945, at 3 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1944 to Oct 28 1945, and that I last saw her alive on Oct 28 1945

Immediate cause of death	Duration
Myocarditis Arteriosclerosis	Gradual
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
(f) Signature W F Moody
Address 140 E Park Ave Date signed 10/30/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G33674

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 C

G33674 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd Street
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days.
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5807 Kenmore Rd. (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME MARY KERWIN LINVILLE

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Charles H. Linville
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 12/31/1869

8. AGE: Years 75 | Months 9 | Days 28 | If less than one day: hr. min.

9. Birthplace: Pennsylvania (Philadelphia) (Town, county, and state)

10. Usual Occupation: None

11. Industry or business

FATHER
12. Name: Michael Kerwin (D)
13. Birthplace: Ireland

MOTHER
14. Maiden Name: Mary Bowers (D)
15. Birthplace: Pennsylvania

16 (a) Informant: Mrs. Robert L. Dandridge
(b) Address: 5807 Kenmore Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 10/31/45 (month) (day) (year)
(c) Cemetery or crematory: Druid Ridge Cem.
Location: Pikesville, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Baltimore, Md.

19 (a) OCT 30 1945 (Date received by Registrar) (b) Registrar

Huntington Hillman

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/29/1945, at 12 23 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/28 1945 to 10/29 1945 and that I last saw her alive on 10/28 1945.

	Duration
Immediate cause of death: Intractable myocardial infarction	
Due to: Arteriosclerotic & Rheumatic heart disease	
Due to: Arteriosclerosis generalized	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation: none
of autopsy: Not done.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Wm. D. Speed M. D.
Address: Union Mem. Hosp. Date signed: 10/30/45

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G33675

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G33675 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
U.S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 16yrs days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2305 Chelsea Terrace
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Hartge, Mary Gertrude

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Sudler Hartge
6 (c) If alive, give age 34 years

7. Birth date of deceased (mo., day, yr.) May 27, 1913

8. AGE: Years	Months	Days	If less than one day
32	5	2	hr. min.

9. Birthplace Miskimon, Va.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George Beane
13. Birthplace Miskimon, Va.

MOTHER
14. Maiden Name Jane Hall
15. Birthplace Nokomos, Va.

16 (a) Informant Records
(b) Address US Marine Hospital, Balto, Md.

17 (a) Burial (b) Date thereof 11/1/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (b)
(Date rec'd by registrar)

OCT 30 1945

Huntington Williams M.D. Registrar

vs. 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 29 1945, at 3:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 2 1945, to Oct. 29 1945, and that I last saw h er alive on Oct. 29 1945.

Immediate cause of death Pulmonary embolus — Duration 10/2/45

Due to Bronchopneumonia due to undetermined cause. Peripheral

Due to neuritis secondary to pneumonia

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Wilson, Sr. Surgeon M. D.
Address Clinical Director Date signed 10/29/45
US Marine Hospital, Balto, Md.

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G33676 LEEF G33676

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N Caroline
(c) Hospital or institution: N. Forest Hospt.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6511 Rosemont Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles H Leef.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Mary E. Leef

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 25 1890

8. AGE: Years 55 Months 2 Days 6 7 If less than one day hr. min.

9. Birthplace Pa.
(Town, county, and state)

10. Usual Occupation printer

11. Industry or business Daily Record

FATHER 12. Name John W. Leef

13. Birthplace Pa

MOTHER 14. Maiden Name Susan Worley

15. Birthplace Pa

16 (a) Informant M. E. Leef

(b) Address 6511 Rosemont Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 31 45 (month) (day) (year)

(c) Cemetery or crematory Parkwood

Location Balto. Md.

18 (a) Funeral director Lasahn Funeral Home

(b) Address 7401 Belair Rd.

19 (a) (Date received by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/28/45 1945 at 6 30 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/28 1945 to 10/28 1945 and that I last saw h[illegible] alive on 10/28 1945.

Immediate cause of death	Duration
Massive Vomiting of Blood.	
Due to Generalized Metastasis	
Due to Carcinomatosis of Abdomen and Chest	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Generalized Carcinomatosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Arthur J. Jaworski M. D.

Address St Joseph Hospt Date signed 10/28/45

VS 150

G33677

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G33677 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 D
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4507 Arabia Ave
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Mabel Wiest

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Joseph Wiest
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 1st 1883

8. AGE: Years	Months	Days	If less than one day.
62	1	29	— hr. — min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation H. W.

11. Industry or business —

FATHER
12. Name Ferdinand Fetsch
13. Birthplace Md.

MOTHER
14. Maiden Name A. Helmsmeier
15. Birthplace Md

16 (a) Informant J. M. Wiest
(b) Address 4507 Arabia Ave.

17 (a) Burial (b) Date thereof 11 2 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Balto. City Md.

18 (a) Funeral director Lagodny Funeral Home
(b) Address 7401 Belair Rd. Waltimore

19 (a) Nov 30 1945 (b) Huntington Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-30-1945, at 3 65/A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-25-1945 to 10-30-1945 and that I last saw her alive on 10-30-1945.

Immediate cause of death	Duration
Cerebral Hemorrage	
Due to Hypertensive Cardio Vascular Disease	
Due to Generalized Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

M. D.
Signature H. K. Karperson
Address Franklin Square Hospital Date signed 10-30-45

G33678

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

'45 C Registered No. G33678

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1604 Darley Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1604 Darley Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: JOHN JACOB SCHAUERMANN

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 212-01-9967

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Nellie Schauermann

6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) Oct. 31, 1884

8. AGE: Years 60 | Months 11 | Days 28 | If less than one day ....hr. ....min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual Occupation: Ship yard worker

11. Industry or business: Bethlehem Steel Co.

FATHER
12. Name: John Jacob Schauermann
13. Birthplace: Germany

MOTHER
14. Maiden Name: Fredericka Scholl
15. Birthplace: Germany

16 (a) Informant: Mrs. Nellie Schauermann
(b) Address: 1604 Darley Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-30-45 (month) (day) (year)
(c) Cemetery or crematory: Baltimore cemetery
Location: Baltimore maryland

18 (a) Funeral director: HENRY SANDER & SONS, INC?
(b) Address: NORTH AVE. & BROADWAY

19 (a) (b) Registrar

OCT 30 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 28, 1945, 5.15 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 28 1945 to Oct 26 1945 and that I last saw h[illegible] alive on Oct 25 1945

Immediate cause of death: Cardiac Decompensation — Duration: Oct 17 1945

Due to:

Due to:

Other Conditions: Acute Bronchitis — 10/28/45

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Morris B. Green M. D.

Address: 3009 Evergreen Ave Date signed Oct 26/45

Huntington Williams, M.D. Baltimore 14 Maryland

VS 150

G33679

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G33679 Registered No.

CWK-96904

Type or print in ink. Do not write in shaded areas. Please read carefully the instructions on the back of this certificate. Be sure to answer all questions correctly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 400 N. Fremont Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Meade

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Widower

6 (b) Name of husband or wife Mary (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 13-1879

8. AGE: Years	Months	Days	If less than one day
66	9	15	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name John Meade
13. Birthplace Maryland

MOTHER 14. Maiden Name Priscilla Foster
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 1, 1945 (month) (day) (year)
(c) Cemetery or crematory
Location Calvary Co. Md.

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

OCT 30 1945 (Date rec'd by registrar) (b) Huntington Wolf, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 28 19 45 at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 25 19 45 to Oct. 28 19 45, and that I last saw him alive on Oct. 25 1945

Immediate cause of death	Duration
Cardiac failure	5 days
Due to Hypertensive cardio-vas. disease	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: HCVD. B.P. ? dilated bladder, hypertension, Cortical atrophy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Margaretta Downs
Address 4940 Eastern Ave. Date signed 10/29/45 (M. D.)

633680

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1108

Registered No. 633680

Please write the causes of death clearly and legibly. Physicians: please correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address ~~2400~~ Eddy wood & Green

(c) Hospital or institution: University Hospital 17-3

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 731 Lemmon St (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) **FULL NAME** Leroy Richardson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Black

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1904

8. AGE: Years 41 | Months | Days | If less than one day hr. min.

9. Birthplace South Carolina (Town, county, and state)

10. Usual Occupation Labor

11. Industry or business

FATHER 12. Name William Richardson

13. Birthplace S. C

MOTHER 14. Maiden Name Mattie Mickel

15. Birthplace S.C.

16 (a) Informant Leroy Richardson

(b) Address 731 Lemmon St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-30-'45 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location

18 (a) Funeral director Mrs. Katie R. Williams

(b) Address 222 N. Schroeder St.

19 (d) OCT 30 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 26 1945, at 7:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/19 1945, to 10/26 1945, and that I last saw him alive on 10/26 1945.

Immediate cause of death	Duration
unknown	
Due to	
Due to	over
Other Conditions Pneumonia	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature J. W. Boggett M.D.

Address University Hosp Date signed 10/26/45

VS 150

633681 633681

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1220

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) 8 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 307 N. Carey St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Emma Hairston

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Fe.	Col.	Married

6 (b) Name of husband or wife Coy Hairston
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1913 - Oct. 10,

8. AGE: Years	Months	Days	If less than one day
34	-	17	hr. min.

9. Birthplace Greenville, S. C. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George Richards
13. Birthplace S. C.

MOTHER
14. Maiden Name Lena Richards.
15. Birthplace S. C.

16 (a) Informant Mrs. Coy Hairston
(b) Address 307 N. Carey St.

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof Oct. 30 '45 (month) (day) (year)
(c) Cemetery or crematory
Location Salisbury, N. C.

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St

19 (a) OCT 30 1945 (Date rec'd by registrar) (b) Thurlington Walker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 27, 1945, at 7:25 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 14, 1945, to Oct. 27, 1945, and that I last saw her alive on Oct. 27, 1945

Immediate cause of death	Duration
Intestinal Ileus	2 days
Due to Mesenteric Thrombosis	4 days
Due to Post-operative Herniaplasty	11 days
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation Oct. 16, 1945
Major findings of operation: Rt. Inguinal Hernia
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. Bradham Stiggins M. D.
Address 2243 Madison Ave. Date signed 10/27/4

VS 150

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

633682

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131

633682 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2618 Evergreen Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William Lee Carlos Carlos

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Louise P.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 17-1868

8. AGE: Years	Months	Days	If less than one day
77	5	17	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation retired Police

11. Industry or business

FATHER
12. Name John Carlos
13. Birthplace England

MOTHER
14. Maiden Name Mary J Moran
15. Birthplace Ireland

16 (a) Informant Mrs. Louise P. Carlos
(b) Address 2618 Evergreen Ave

17 (a) Buried (b) Date thereof 11-2-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Lorraine
Location Balto

18 (a) Funeral director Leonard J. Ruck
(b) Address 532 Wayford Rd.

19 OCT 30 1945 (b) [illegible] Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-29-1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/2 1945, to 10/29 1945, and that I last saw him alive on 10-29 1945

Immediate cause of death	Duration
Cerebro-respiratory failure	
Due to Cerebral decompensation	
Due to Generalized arteriosclerosis	
Other Conditions Hypertension, Chronic nephritis, Cataract	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Eugene J. Libby M.D.
Address 1900 Mercy Date signed 10-30-45

VS 150

633683

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1318

Registered No. 633683

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address or location: Mercy Hosp 9
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1613 Lamont Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country No

3 (a) **FULL NAME** Mary Kohrs

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6. (b) Name of husband or wife William Kohrs
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 7 1906

8. AGE: Years	Months	Days	If less than one day
39	2	22	hr. min.

9. Birthplace Balto. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William Shade
13. Birthplace Balto. County

MOTHER
14. Maiden Name Margaret Gleason
15. Birthplace Ireland

16 (a) Informant William Kohrs
(b) Address 1613 Lamont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-2-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto.

18 (a) Funeral director Leonard J. Ryck
(b) Address 5305 Harford Road

(Date received by local registrar) OCT 30 1945 (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/29/45 19 at 9:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/18 1945 to 10/29 1945 and that I last saw her alive on 10/29 1945

Immediate cause of death	Duration
Uremia & Acidosis	
Due to Chronic Glomerulo Nephritis	
Due to Pyelonephritis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles Strahan M. D.
Address Mercy Hosp Date signed 10/29/45

X

633684

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 633684 / 145a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Md.
(c) Hospital or institution: Woman's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1313 Mt. Royal Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sophia Blachut

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1920

8. AGE: Years 25 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Uniontown, Pa. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Michael Bla chut
13. Birthplace Ga licia, Poland

MOTHER
14. Maiden Name Margarete Zelak
15. Birthplace Galicia, Poland

16 (a) Informant Miss Blanche Blachut
(b) Address 1313 Mt. Roya l Ave.

17 (a) ~~Burial, cremation or~~ removal (b) Date thereof 10/30/45 (month) (day) (year)

(c) Cemetery or crematory
Location Uniontown, Penna.

18 (a) Funeral director Leonard J. Rucke
(b) Address 5730 Harford Rd. (14)

OCT 30 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 29, 1945, at 5:55 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to ~~her~~ death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pyelonephritis

Due to

Other Conditions Pregnancy (3 mo.)
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skitarelic M.D. Medical Examiner.
Date signed October 30, 1945

VS 151 (OVER)

633685

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 633685

Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2932 St. Paul St.
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2932 St. Paul St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Wallace Bell

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Edna C.
6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) Nov. 11, 1867

8. AGE: Years 77 | Months 11 | Days 14 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name William W. Bell
13. Birthplace Baltimore

MOTHER
14. Maiden Name Caroline Baudel
15. Birthplace Baltimore

16 (a) Informant Mrs. Edna C. Bell
(b) Address 2932 St. Paul St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/31/45 (month) (day) (year)
(c) Cemetery Greenmount
Location North & Greenmount Aves.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) Filed OCT 30 1945 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 28 1945, at 3 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 24, 1945 to Oct. 28, 1945 and that I last saw h alive on Oct. 28, 1945

Immediate cause of death: Cardiac Failure — Duration: 5 days.
Due to: Chronic myocarditis. — ?
Due to: Hypertension — ?
Other Conditions: Old Cerebral Hemorrhage — Years ?

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation: none
of autopsy: none.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ~
(b) Date of occurrence ~ at ~ M
(c) Where did injury occur? ~ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ~ (Specify type of place) While at work? ~
(e) Means of injury

23. Signature Frank M. Ogden M. D.
Address 2701 N. Calvert St. Date signed

VS 150

G33686 **HEALTH DEPARTMENT—CITY OF BALTIMORE** G33686

CERTIFICATE OF DEATH 1108

1. PLACE OF DEATH — Registered No. .....

CITY OF BALTIMORE: (No. 1000 N. Wolfe St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S. If of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME Emmett Mills Ashe Jr

If U. S. Veteran specify WAR .....

(a) Residence: No. 1000 N. Wolfe St St., ... Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
M	C	Married

5a. If married, widowed, or divorced — HUSBAND of (or) WIFE of Married

6. DATE OF BIRTH (month, day, year) 1870

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	75			

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Labor

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Portsmouth Va

FATHER

13. NAME Unknown

14. BIRTHPLACE (city or town) (State or country)

MOTHER

15. MAIDEN NAME Unknown

16. BIRTHPLACE (city or town) (State or country)

17. INFORMANT Roberta Ashe

(Address) 1000 N. Wolfe St

18. BURIAL, CREMATION, OR REMOVAL

Place Mt. Auburn Cemetery Date 10-30 1945

19. UNDERTAKER Elroy O. Wilson

(Address) 1024 Brantly ave

20. OCT 30 1945 Huntington Williams Registrar

OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Oct 28 1945

22. I HEREBY CERTIFY, That I attended deceased from Oct 14 1945 to Oct 27 1945

I last saw him alive on Oct 27 1945. Death is said to have occurred on the date stated above, at 11 A.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Lobar Pneumonia	Sick
Other contributory causes of importance: Exposure	

Was an operation performed? ..... Date of .....

For what disease or injury? .....

Name of operation ..... What test confirmed diagnosis? Medical Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ..... 19....

Where did injury occur? .....
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place .....

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? ..... If so, specify .....

(Signed) J. H. Walter M. D.

(Address) 1443 E Eager

V2 8

X

633687

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

633687 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 615 S. Bethel Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town 615 S. Bethel St.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Andrzey Lukasiewicz

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-01-0381

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1860

8. AGE: Years 85 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name unknown
13. Birthplace Poland

MOTHER 14. Maiden Name unknown
15. Birthplace Poland

16 (a) Informant Mrs. Frances Nowak
(b) Address 615 S. Bethel Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 31 45 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem
Location Baltimore County

18 (a) Funeral director John M. Weber
(b) Address 401 S. Chester Street

19 (a) (b) (Date received by registrar)

VS Form OCT 30 1945

Huntington R. Williams, M.D.

MEDICAL CERTIFICATION 8 15

20. DATE OF DEATH Oct 29 1945; at A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1 4 1937 to 10 29 1945, and that I last saw h[illegible] alive on 10 29 1945

Immediate cause of death: Acute Cardiac Substitution — Duration

Due to:

Due to: Chron Myocardial failure

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature S C Feldman

Address 144 E Balt Date signed 10/31/45

X

633638

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 162B

633638 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Maryland Gen. Hosp 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mo
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2518 Ellamont Ave
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Mr. Charles Dietz

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Alice B. Dietz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 11. -1865

8. AGE: Years	Months	Days	If less than one day
80	5.	18	....hr. ....min.

9. Birthplace Baltimore (Town, county and state)
10. Usual Occupation Retired Pattern Maker
11. Industry or business

FATHER
12. Name George Dietz
13. Birthplace Germany.

MOTHER
14. Maiden Name Cornelia J. Shuler
15. Birthplace Virginia

16 (a) Informant Alice B. Dietz
(b) Address 2518 Ellamont ave

17 (a) Burial (b) Date thereof Nov. 1-1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Louden Park Cem.
Location Baltimore

18 (a) Funeral director Mamie Berk. Syfer
(b) Address 1600 W. North Ave

19 (a) OCT 30 1945 (b) Huntington Wilkins Baltimore, Md.
(Date received by local registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 29 1945 12:30 P

21. I certify that death occurred on the date above stated; that I attended deceased from 9-29 1945 to 10-29 1945
and that I last saw him alive on 10-29 1945

Immediate cause of death Heart failure — Duration
Due to old age
Due to
Other Conditions Fract of right femur, healed
(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence.....at.....M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?.....While at work?.....
(Specify type of place)
(e) Means of injury.....

23. Signature Augustus A. Gray M.D.
Address M.G. Hosp. Date signed 10-29-45

633689

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 61

633689

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Harford
(c) City or town Aberdeen
(If outside city or town limits, write RURAL and give town)
(d) Street No. R F D # 2
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Mary Lewis Bailey

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W	M

6 (b) Name of husband or wife Harry Delaney Bailey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 25 1873

8. AGE: Years	Months	Days	If less than one day
71	11	3	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Phillip Hawkins
13. Birthplace Connecticut

MOTHER
14. Maiden Name Elizabeth James
15. Birthplace Maryland

16 (a) Informant Gospeth Woods
(b) Address Balto Md

17 (a) Burial (b) Date thereof Oct. 31/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Churchville
Location Churchville Harford Co. Md

18 (a) Funeral director Mervey Tavenner Flory
(b) Address Aberdeen Md

19 (a) (b)
(Date received by registrar) Huntington Williams, M.D.

OCT 30 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 28 1945, at 11:35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 25 1945 to Oct 28 1945 and that I last saw h/ alive on Oct 28 1945

Immediate cause of death Lobar Pneumonia	Duration
Due to	
Due to	
Other Conditions Diabetes Mellitus	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo. W. Mungavin Jr. M. D.
Address 302 E University Pkwy. Date signed 10/22/45

108

G33690

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

99

G33690

Registered No.

Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Loudoun and Green Sts

(c) Hospital or institution; University of Md Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md Va (b) County

(c) City or town Renick W. Va

(If outside city or town limits, write RURAL and give town)

(d) Street No. —

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Ross Hanna - Julian A Hanna

3 (b) If veteran, name war — None

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 13, 1907

8. AGE: Years 38 | Months 8 | Days 17 | If less than one day hr. min.

9. Birthplace Fares Hill W. Va

(Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business

FATHER

12. Name Alexander H. Hanna

13. Birthplace Fares Hill W. Va

MOTHER

14. Maiden Name Mollie A. McMillen

15. Birthplace Fares Hill W. Va.

16 (a) Informant Mrs Mollie B. Hanna

(b) Address Fares Hill W. Va

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 2/45 (month) (day) (year).

(c) Cemetery or crematory Renick Cemetery

Location Renick W. Va

18 (a) Funeral director Elmer W Conley & Son

(b) Address 924 E. Eager St.

19 (a) (Date received by registrar) (b) Registrar

OCT 30 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/30 1945 at 2:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/17 1945 to 10/30 1945 and that I last saw him alive on 10/30 1945

Immediate cause of death Gangrene, Toxemia

Due to Emergency to Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Roy H. Hall, Jr. M. D.

Address Admin. Hosp. Date signed 10/30/45

G33691

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 127a

G33691 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1607 E Lombard st
(c) Hospital or institution: 3

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 607-E. Lombard (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hennie Brown Williams nee Miles
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Charles W. Miles
6 (c) If alive, give age 51 years
7. Birth date of deceased (mo., day, yr.) 1897
8. AGE: Years 48 | Months | Days | If less than one day ... hr. ... min.
9. Birthplace Propect Va (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William Brown
13. Birthplace Propect. Va.

MOTHER
14. Maiden Name Virginia Baker
15. Birthplace Propect. Va.

16 (a) Informant Charles W. Miles
(b) Address 1607 E Lombard st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10. 31. 45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Brooklyn Md

18 (a) Funeral director Mrs Ida Bailey
(b) Address 421 Jefferson St

19 (a) (b) Registered by registrar Huntington Willis Registrar

OCT 30 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October, 28 1945, at 6:00 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/21 — 1945, to 10/28 1945, and that I last saw him alive on 10/28/1945.

Immediate cause of death: Acute Alcoholism Heart Failure

Duration: Acute

Due to: Diabetes Mellitus

Duration: Chronic

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. R. J. Blake M. D.
Address 1327 N. Carrollton Date signed 10/29/45

PHYSICIAN

Underline the cause to which death should be charged statistically.

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G33692 BALTIMORE CITY HEALTH DEPARTMENT G33692
CERTIFICATE OF DEATH 168 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Penna. (b) County York County
(c) City or town Delta
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Daniel Joseph Dougherty

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) [illegible] 29, 1904

8. AGE: Years	Months	Days	If less than one day
41	0	1	hr. min.

9. Birthplace York Co Pa (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business Farming

FATHER
12. Name Frank Dougherty
13. Birthplace York Co Pa

MOTHER
14. Maiden Name Mary Dougherty
15. Birthplace York Co Pa

16 (a) Informant Hospital Record
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 4 1945 (month) (day) (year)
(c) Cemetery or crematory St Mary
Location Pylesville Md

18 (a) Funeral director H Harvey Webb
(b) Address Havre de Grace Md

19 (a) NOV 1945 (Date received by Registrar) (b) Registrar
Huntington Williams, MD

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 20 1945; at 7 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Fracture of skull

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Oct 24 1945
(b) Where did injury occur? Delta, Pa.
(c) Did injury occur at home, on farm, industrial place, in public place? Farm While at work? No
(d) Means of injury Struck c piece of timber

23. Signature Richard Lee Sutton M.D.
Medical Examiner.
Date signed Oct 20 1945

G33693 482549. BALTIMORE CITY HEALTH DEPARTMENT G33693 Registered No.

CERTIFICATE OF DEATH 48a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3805 Roadenhall St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Phyllis Dorsey

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-24-8716

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife M. Dorsey
6 (c) If alive, give age Not alive

7. Birth date of deceased (mo., day, yr.) 4-17-05

8. AGE: Years	Months	Days	If less than one day
40	6	12	hr. min.

9. Birthplace W. Va. (Town, county, and state)
10. Usual Occupation Home-wife
11. Industry or business

FATHER 12. Name Preston Dorsey.
13. Birthplace W. Va.

MOTHER 14. Maiden Name Theresa Gray
15. Birthplace W. Va.

16 (a) Informant Relative
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Nov. 2-45 (month) (day) (year)
(c) Cemetery or crematory Walnut Grove Cemetery
Location Fairmont West Virginia

18 (a) Funeral director Milton Schilling
(b) Address 3914 S. Hanover St.

19 Rec'd by registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct-29 1945, at 1:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 24 1945, to Oct. 29 1945, and that I last saw h. alive on Oct. 29 1945

	Duration
Immediate cause of death Uremia	7 days
Due to Carcinoma cervix	2 yrs
Due to Metastasis to ureter bilateral	1 yr
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy: Not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature David B. Cheek M. D.
Address Johns Hopkins Hospital Date signed

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G33694 BALTIMORE CITY HEALTH DEPARTMENT G33694
CERTIFICATE OF DEATH 1945 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write; the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 216 Washburn Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 yrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto 25 Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 216 Washburn Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John G. Baumann
3 (b) If veteran, name war
3 (c) Social Security Account No. 213-05-4651A

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower
6 (b) Name of husband or wife: Isabelle Baumann
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct 21-1877
8. AGE: Years 68 | Months - | Days 9 | If less than one day hr. min.
9. Birthplace Balto - Md (Town, county, and state)
10. Usual Occupation Retired Attorney Engineer
11. Industry or business American Oil Co

FATHER
12. Name Geo Baumann
13. Birthplace Germany

MOTHER
14. Maiden Name Marie Anna Madeira
15. Birthplace Bremen Germany

16 (a) Informant Mrs Lillian Howard
(b) Address 216 Washburn ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 3-45 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Gov Ritchie Highway
18 (a) Funeral director Milton Schilling
(b) Address 30 1943 14 S. Hanover St-25
19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 30th 1945, at 12.20 M
21. I certify that death occurred on the date above stated; that I attended deceased from August 1942 to Oct. 1945 and that I last saw him alive on Oct. 30 1945.

	Duration
Immediate cause of death: Chronic myocarditis	3 yrs.
Due to: Arteriosclerotic Heart Disease	3 yrs.
Due to:	
Other Conditions: Pulmonary Edema (Include pregnancy within 3 months of death)	2 hrs.

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury —
23. Signature R. J. Arnold M. D.
Address 4609 Gov. Ritchie Highway Date signed 10-30-45

VS 180 Huntington Williams, Registrar

Balto 25, Md X

633695

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. 633695

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Levendale Home
(c) Hospital or institution:
Belvedere Ave & Greenspring Ave
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Levendale Home
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Jacob Rothstein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Late Lena
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1860

8. AGE: Years	Months	Days	If less than one day
85			hr. min.

9. Birthplace Poland
(Town, county, and state)
10. Usual Occupation
11. Industry or business Retired

FATHER
12. Name Philip Rothstein
13. Birthplace Poland

MOTHER
14. Maiden Name Celia ?
15. Birthplace Poland

16 (a) Informant Mrs Harry Miller
(b) Address 3615 Reisterstown Road

17 (a) Burial (b) Date thereof Oct. 31, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Washington Road
Location Washington Blvd

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) (Signature of local registrar) (b) Huntington Williams, M.D.

OCT 31 1945

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH October 30 1945, at 5:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-25 1944, to 10-30 1945, and that I last saw h[illegible] alive on 10-30 1945

Immediate cause of death	Duration
Cerebral Hemorrhage	10-27-45
Due to Hypertension, Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Edmund Davis
Address Lutindale Date signed 11/30/45

correct are is especially important. Physicians: please write the causes of death clearly and legibly.

633696

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 942

Registered No. 633696

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 721 E. 22nd Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ---
(e) Length of stay in Baltimore (yrs., mos., or days) 78 (68) Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County --------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 721 E. 22nd Street
(If rural give location)
(e) Citizen of foreign country? -------- (Yes or No)
If yes, name country --------

3 (a) FULL NAME Albert V. Tuttle

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Helen L. Wright
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) November 10 1866

8. AGE: Years	Months	Days	If less than one day
78 (68)	---	---	-- hr. --- min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Teacher of Dancing
11. Industry or business ---------

FATHER
12. Name Charles Tuttle
13. Birthplace Maryland

MOTHER
14. Maiden Name Rebecca Hall
15. Birthplace Snow (Sun) Hill, Md.

16 (a) Informant Mrs. Helen L. Tuttle
(b) Address 721 E. 22nd Street

17 (a) Burial (b) Date thereof 11/1/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Baltimore, Md.

18 (a) Funeral director H. W. Meads and Son
(b) Address 805 N. Calvert Street

19 (a) Date rec'd OCT 31 1945 (b) Registrar Huntington Williams, M.D.
Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/29/1945, at 5:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/29/1945, to 10/29/1945, and that I last saw h[illegible] alive on 10/29/1945

Immediate cause of death	Duration
Coronary Occlusion	4 hours
Due to Coronary Arteriosclerosis	1 year
Due to Coronary Arteriosclerosis	?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas F. Waite M. D.
Address 592 E 22nd St Date signed 10/30/45

Please write the causes of death clearly and legibly. Age is especially important. Physicians: please write

633697 VAN ORDER 93D 633697

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Paulskie Sts.
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3503 Menlo Drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mr. Thomas H. Van Order

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M.

5. Color or race W.

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of ~~husband~~ or wife Grace Burns

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 27, 1875

8. AGE: Years 70 | Months 7 | Days 3 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Traffic manager

11. Industry or business W.U. Tel Co.

FATHER
12. Name Egbert Van Order
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Catherine Reilly
15. Birthplace Baltimore, Md.

16 (a) Informant Grace H. Van Order
(b) Address 3503 Menlo Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/1/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location Dundalk, Md.

18 (a) Funeral director Martin Baker & Sons
(b) Address 1827 W. North Ave.

DEC 7 1945 (Date received by Registrar) (b) Huntington Williams, M.D.

VS 350

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/30 1945 at 4:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/31 1945 to 10/30 1945 and that I last saw him alive on 10/30 1945

Immediate cause of death Coronary Thrombosis — Duration 10 days.

Due to Generalized arteriosclerosis & Chronic Myocarditis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature F. L. Strickland Jr. M.D.

Address Bon Secours Hosp. Date signed 11/2/45

G33698 CIRONER ✓

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G33698

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address NORTH BROADWAY
(c) Hospital or institution: CHURCH HOME & HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days) 2 DAYS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE - 24 (If outside city or town limits, write RURAL and give town)
(d) Street No. 615 S. ROBINSON ST. (If rural give location)
(e) Citizen of foreign country? DO. (Yes or No)
If yes, name country

3 (a) FULL NAME BABY BOY CORNER

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife NONE

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-27-45

8. AGE: Years	Months	Days	If less than one day
		1½	hr. min.

9. Birthplace BALTIMORE, MARYLAND. (Town, county, and state)

10. Usual Occupation (INFANT)

11. Industry or business

FATHER
12. Name RUSSELL CORNER
13. Birthplace BALTIMORE, MD.

MOTHER
14. Maiden Name BESSIE WEST
15. Birthplace MARYLAND

16 (a) Informant BESSIE W. CORNER
(b) Address 615 S. ROBINSON ST., CITY.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location PUBLIC CEMETERY OCT 30 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 OCT 31 1945 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-28 1945 at 7 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-27 1945 to 10-28 1945 and that I last saw him alive on 10-28 1945

Immediate cause of death PREMATURE BIRTH — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: NOT PERFORMED.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James B Lattimer M. D.
Address Church Home & Hosp. Date signed 10-29-45

VS 150

X

633699

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No. 633699

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians:

3700

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74 2

G33700

Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2220 Riggs Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2220 Riggs Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ALLEN FREDERICK KLAGES

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 21, 1928

8. AGE: Years	Months	Days	If less than one day
17	1	7	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Student
11. Industry or business

FATHER
12. Name Frederick H. Klages
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Ella W. Letmate
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Frederick H. Klages
(b) Address 2220 Riggs Ave.

17 (a) Burial (b) Date thereof 10/31/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 31 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 28, 1945 at 9:15 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 11, 1944 to Oct. 28, 1945 and that I last saw him alive on Oct. 27, 1945

Immediate cause of death: Myelogenous leukemia

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George H. Klages

Address 3030 Edmondson Ave. Date signed 10/29/45

G33701

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 C

G33701 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Joseph's Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2607 Garrett ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph S. Starr

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Marie Starr
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 28 1908

8. AGE: Years	Months	Days	If less than one day
37	2	1	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business Grain & Hay Dairy

FATHER
12. Name Joseph A. Starr
13. Birthplace Md.

MOTHER
14. Maiden Name Anna Murray
15. Birthplace Md

16 (a) Informant Marie Starr
(b) Address 2607 Garrett Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/31/45 (month) (day) (year)
(c) Cemetery or crematory St Josephs
Location Govans Md

18 (a) Funeral director Milton Cook Inc
(b) Address 1219 Light St

19 (a) (Date received by registrar) (b) Registrar

OCT 31 1945

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-29 1945, at 5.50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-11 1945 to 10-29 1945, and that I last saw him alive on 10-29 1945.

Immediate cause of death	Duration
Cardio-Respiratory Failure	
Due to Rheumatic C.V.D	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. E. Robertson M. D.
Address St. Josephs Hosp Date signed 10-29-45

X

Huntington Williams, M.D.

Please write the causes of death clearly and legibly. Physicians: please write age is especially important.

G33702

AB-96944

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G33708

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2days
(e) Length of stay in Baltimore (yrs., mos., or days) 21yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 820 N. Bond St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Stewart

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 3-1921

8. AGE: Years 24 | Months 4 | Days 27 | If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Albert Stewart
13. Birthplace Pa.

MOTHER
14. Maiden Name Mattie Beasley
15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals(Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-2-45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvery
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Broadway for Huntington Ave & Mt Royal Ave

19 (a) OCT 31 1945 (Date received by Registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 30- 1945, at 5.30A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-28- 1945 to 10-30- 1945, and that I last saw her alive on 10-30- 1945.

Immediate cause of death: Diabetic acidosis and coma — Duration
Due to: Diabetes Mellitus unregulated
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jonathon Howeland M. D.
Address B C H. Date signed 10/30/45

G33703

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92D

G33703 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2430 Edmondson Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2430 Edmondson Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Philip C. Newberry

3 (b) If veteran, name war: yes
3 (c) Social Security Account No. 214-03-3794

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Catherine L Newberry
6 (c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) Feb 9th 1899

8. AGE: Years 46 | Months 8 | Days 21 | If less than one day hr. min.

9. Birthplace Plymouth N.C. (town, county, and state)
10. Usual Occupation Salesman
11. Industry or business

FATHER
12. Name Linwood Newberry
13. Birthplace Plymouth N. C.

MOTHER
14. Maiden Name Lena Reed
15. Birthplace Plymouth N. C.

16 (a) Informant Catherine L Newberry
(b) Address 2439 Edmondson Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-2-45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem
Location

18 (a) Funeral director Charles P Powell
(b) Address 2427 Edmondson Ave

19 (a) (b) Huntington Williams, Asst.

OCT 31 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 30th 1945, at 8:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1945 to Oct 30 1945, and that I last saw him alive on Oct 30 1945

Immediate cause of death Coronary Thrombosis: Chronic Endocardial and

Duration
12 hours
Years
4
Months
Days

Due to Myocardial disease with Cardiac hypertrophy

Due to Arteriosclerosis Failure

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. Winchel M. D.
Address 2901 Edmondson Date signed Oct 30 45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

633704

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Guy 47E

633704 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkins & Caton Ave
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo 13
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 818 Chauncey Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mrs Carrie R. Cohn (Carrie R. Cohn)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband ~~Carrie~~ Wm. Cohn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 15, 1872

8. AGE: Years	Months	Days	If less than one day
72	11	15	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Maker
11. Industry or business

FATHER
12. Name Gabriel Rosenfeld,
13. Birthplace Germany

MOTHER
14. Maiden Name Hetta Eisinby,
15. Birthplace Germany

16 (a) Informant (Mrs.) Clarence B. Cohn
(b) Address 5716 Oakshire Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/31/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ New Sinai
Location Balto. Md.

18 (a) Funeral director Harris Sondheimer Sons
(b) Address 1902 Eutaw Place

19 (a) ~~Embalmer~~ (b) Registrar

OCT 31 1945

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/30 1945, at 1 22 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 2 1944 to 10/30 1945, and that I last saw Her alive on 10/30 1945.

Immediate cause of death	Duration
Cardio Respiratory failure	
Due to Endothelioma of left pleura	
Due to	
Other Conditions Arteriosclerosis & mal nutrition (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Cliff Rabkin, Jr. M. D.
Address St. Agnes Hosp. Date signed 10/30/45

G33705

CWK-94085

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93D

G33705
Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0- 4- 19 days
(e) Length of stay in Baltimore (yrs., mos., or days) 83- 3- 0-

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 710 N. Broadway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Reichart

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 28-1862

8. AGE: Years	Months	Days	If less than one day
83	3	0	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name Henry Reichart (D)
13. Birthplace Germany

MOTHER
14. Maiden Name Christine Heimsteck (D)
15. Birthplace Germany

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof 10/31/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Camp Chapel
Location E. Joppa Road

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 N. Broadway

19 (a) (b)
(Date rec'd by registrar)

OCT 31 1945

Hunting for Health Baltimore Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 28 1945; at 5:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 9 1945, to Oct. 28 1945 and that I last saw him alive on Oct. 28 1945.

Immediate cause of death	Duration
Hypertension + arteriosclerotic Heart Disease	?
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Margaret M. Davis M. D.
Address 4940 Eastern Ave. Date signed 10-30-45

633706

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1190

633706 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ~~1900 E.~~
(c) Hospital or institution:
University Hosp. 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7d
(e) Length of stay in Baltimore (yrs., mos., or days) 9 mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State V (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 18 N Calhoun St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Hilda M. Leisner

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 29, 1944

8. AGE: Years | Months 10 | Days — | If less than one day ... hr. ... min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Frank Leisner
13. Birthplace Md

MOTHER 14. Maiden Name Hilda Besser
15. Birthplace Md

16 (a) Informant Mrs. Frank P. Leisner
(b) Address 18 N. Calhoun St

17 (a) Burial (b) Date thereof 10-31-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Brooklyn Md

18 (a) Funeral director Wesley H. Wiltze
(b) Address 4101 Edmondson Ave

19 (a) (Date) (by registrar) (b) Huntington Williams, M.D.

OCT 31 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/29 1945, at 8-45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/28/ 1945, to 10/29 1945, and that I last saw h⊂R alive on 10/27 1945.

Immediate cause of death Anaphemia — Duration

Due to Pneumonia

Due to

Other Conditions Severe diarrhea

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. M. Scott M. D.
Address Community H. Date signed

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

633707

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

633707 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 22 S. Athol, Ave.
(c) Hospital or institution:
General German Aged Peoples Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 22 S. Athol Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Maggie Reed

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or late Edwin Reed

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 17 1856

8. AGE: Years 89 | Months 6 | Days 11 | If less than one day ..... hr. ..... min.

9. Birthplace Pa
(Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name John Smith
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Blank
15. Birthplace Germany

16 (a) Informant Mr. J. George Walz, Sect'y
(b) Address 22 S. Athol Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 31/45. (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director Harry H. Nitzke
(b) Address 4101 Edmondson Ave.

19 (a) (Date received by registrar) OCT 31 1945 (b) Registrar

MEDICAL CERTIFICATION 2 P.M.

20. DATE OF DEATH Oct 28 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 16/45, to Oct. 28/45, and that I last saw h. alive on Oct. 26/45.

Immediate cause of death	Duration
Broncho-Pneumonia	4 days.
Due to	
Due to	
Unknown.	
Other Conditions Arterio-Sclerosis.	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry Wade Chandler, M. D.
Address 923 Hanover Date signed Oct. 30/45

Huntington Williams, M.D.

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G33708

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G33708 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1719 W. Lafayette Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and name county)
(d) Street No. 1719 W. Lafayette Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie L. Boardley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F. | 5. Color or race C. | 6 (a) Single, married, widowed or divorced. Widowed

6 (b) Name of husband or wife Charles

6 (c) If alive, give age (D) years

7. Birth date of deceased (mo., day, yr.) Sept 10, 1865

8. AGE: Years 80 | Months 1 | Days 18 | If less than one day ____ hr. ____ min.

9. Birthplace Snow Hill, Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Eulalia Stevenson
(b) Address 1719 W. Lafayette Ave

17 (a) Burial (b) Date thereof 10/31/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Zion
Location Balto., Md.

18 (a) Funeral director Joseph B. Luckett
(b) Address 1334 N. Central Ave

19 (a) (b) Huntington, W. Va.
(Date rec'd by registrar)
OCT 31 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-28 1945, at 7:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/27/1945 to 10-28-1945; and that I last saw h[illegible] alive on 10/27/1945.

Immediate cause of death	Duration
Coronary Occlusion	
Due to	
Due to Hypertension	
Other Conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address 1200 N. [illegible] Ave. Date signed 10/30/45

G33709

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93C

Registered No. G33709

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town RURAL
(If outside city or town limits, write RURAL and give town)
(d) Street No. 121 Walnut St. Balto - 20.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country Turners Station

3 (a) FULL NAME Chris Woods

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 3-11-1928

8. AGE: Years	Months	Days	If less than one day
17	8	19	hr. min.

9. Birthplace South Carolina (Town, County, and state)
10. Usual Occupation School
11. Industry or business

FATHER
12. Name Willie Woods
13. Birthplace S.C.

MOTHER
14. Maiden Name Sally Jackson
15. Birthplace S.C.

16 (a) Informant Willie Woods
(b) Address 121 Walnut ave.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 11-2-45 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Arbutus Md

18 (a) Funeral director Williams & Jackson
(b) Address 916 Penna. ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams Registrar

VS OCT 31 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/30 1945, at 2:38 A. M

21. I HEREBY CERTIFY, That I took charge of the remains described above, held an Inspection (Autopsy or Inquiry) thereon and from the evidence obtained by said Inspection (Autopsy or Inquiry) and that said deceased came to his death on the day stated above.

Immediate cause of death: Rheumatic Cardio-vascular disease — Duration
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dr. Charles B. McNally M.D. Medical Examiner.
Date signed 10/30/45

33710

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 15

G33710
Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1034 W Franklin
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1034 W Franklin
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie Jackson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-2-11

8. AGE: Years 34 | Months 1 | Days 24 | If less than one day hr. min.

9. Birthplace D. C.
(Town, county, and state)

10. Usual Occupation Nur.

11. Industry or business

FATHER
12. Name unknown
13. Birthplace D.C.

MOTHER
14. Maiden Name Lula Carwell
15. Birthplace D.C.

16 (a) Informant Mrs. Margaret Jackson.
(b) Address 1034 W. Franklin St.

17 (a) Burial (b) Date thereof Oct. 31, '45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 S Schroeder St

19 (a) 11 1945 (b) Huntington Williams M.D.
Date filed by Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-26- 1945, at 10 1/2 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-16 1945, to 10-26 1945, and that I last saw h[illegible] alive on 10-26 1945.

Immediate cause of death: Tubercular Pentonitis — Duration: 1 year
T.B. Bronchus

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 10/30/45

633711

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

633711 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution Mercy Hosp 8
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6d.
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town BALTIMORE - 13
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2211 E. Muca St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country No

3 (a) FULL NAME Josephine Maciacaya

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	M

6 (b) Name of husband or wife Louis Maciacaya
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 24 1893

8. AGE: Years	Months	Days	If less than one day
51 52	10	6	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name John Carl
13. Birthplace Baltimore

MOTHER
14. Maiden Name Josephine Carl
15. Birthplace Md

16 (a) Informant Louis Maciacaro
(b) Address 2211 Muca St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 2 1945 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Leo G. Leacock
(b) Address 1701-03 N. Patterson Park Ave

19 (a) (Date rec'd by Registrar) (b) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/30/45 19 , at 8:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/24 1945, to 10/30 1945, and that I last saw h[illegible] alive on 10/30 1945.

Immediate cause of death Cerebral Hemorrhage Accident — Duration

Due to Hypertension / benign essential

Due to Pneumonia

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles Straker M. D.
Address Mercy Hosp Date signed 10/30/45

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

633712 BALTIMORE CITY HEALTH DEPARTMENT 633712
CERTIFICATE OF DEATH 108 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1517 Brevard St (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Jesse James Lomax
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years 49 | Months | Days | If less than one day hr. min.

9. Birthplace Georgia (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER 12. Name unknown
13. Birthplace

MOTHER 14. Maiden Name
15. Birthplace

16 (a) Informant Mrs. E. Murray
(b) Address 1517 Brevard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 2 1945 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Bristol Hill Ave

19 (a) (Date received by Registrar) (b) Huntington Williams, M.D. Registrar
OCT 31 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/26 1945, at 4 05 M

21. I certify that I took charge of the remains described above, held an Inspection - Inquest Autopsy, Inspection or Inquiry and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to ... death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Lobar Pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Lubrinski M.D. Medical Examiner.
Date signed 10/27/45

VS 151

633713 BALTIMORE CITY HEALTH DEPARTMENT 633713

CERTIFICATE OF DEATH 1313

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1112 Penna. Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1112 Penna. Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marshall Green

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 10, 1904

8. AGE: Years 41 | Months 7 | Days 15 | If less than one day hr. min.

9. Birthplace South Carolina (Town, county, and state)

10. Usual Occupation Stevedore

11. Industry or business

FATHER 12. Name Mike Green
13. Birthplace S. C.

MOTHER 14. Maiden Name Louella
15. Birthplace S. C.

16 (a) Informant Lula Pickens
(b) Address 532 Lanvale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-31-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

19 (a) OCT 3 1945 (b)
Date received by Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 25, 1945, at 8:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/8 1945 to 10/25 1945 and that I last saw him alive on 10/24 1945

Immediate cause of death: Lobar Pneumonia — Duration

Due to

Due to

Other Conditions (over)

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature
Address 201 N. Collington Date signed 10/26/45 M. D.

VS 150

G33714

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G33714 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 635 Mosher Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 635 Mosher Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CLAUDE McGEE

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Lillian McGee
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10, 1890

8. AGE: Years	Months	Days	If less than one day
55	5	18	hr. min.

9. Birthplace Wilmington, N. C.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Jeremiah McGee
13. Birthplace N. C.

MOTHER
14. Maiden Name Ann ?
15. Birthplace N. C.

16 (a) Informant Mrs. Lillian McGee
(b) Address 635 Mosher Street

17 (a) Burial (b) Date thereof 11-1-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvert Cem.
Location A. A. Co., Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) (b) Registrar
(Date rec'd by registrar)

Huntington Williams, M.D.

VS 150 OCT 31 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH October 28, 1945, at 2:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-19-45 to 10-28-45, and that I last saw h. alive on 10-26-45

Immediate cause of death	Duration
hypostatic pneumonia	10 days
Due to cerebral hemorrhage left hemiplegia	7 days
Due to hypertensive cardiovascular disease	6 mos.
Other Conditions: —	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN. Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James D. Carr M. D.
Address 515 Mosher St Date signed

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

633715

HEP #96827

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1/31

Registered No. 633215

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 57-7 & 12

17

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1334 Argyle Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helen Gross

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 15, 1888

8. AGE: Years	Months	Days	If less than one day
57	7	12	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Charles Janie
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Gantt
15. Birthplace Maryland

16 (a) Informant Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-1-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.
18 (a) Funeral director Mt. Frances J. Heuisler
(b) Address 578 W. Baltimore St.
19 (a) (Date received by Registrar) NOV 31 1945 (b) Huntington, Williamsport

MEDICAL CERTIFICATION A

20. DATE OF DEATH Oct. 27, 1945, at 12:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 22, 1945 to Oct. 27, 1945 and that I last saw h[illegible] alive on Oct. 27, 1945

Immediate cause of death	Duration
Cardiac failure and uremia	
Due to Hypertensive cardiovascular disease	
Due to Nephrosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Jonathan Howland M. D.
Address 5 E 10. Date signed 11/2/45

X

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G33716

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G33716 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Hampnett Ave.
(c) Hospital or institution:
Hampnett Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 0 9
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3329 W. Caton Ave. N. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN HEBB BROWN

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 212-16-3768

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Clara Cordelia Brown

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jul. 4. 1858

8. AGE: Years 89 | Months 4 3 | Days 24 | If less than one day ____hr. ____min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Standard Fruit Co.

11. Industry or business Retired

FATHER
12. Name Henry Brown
13. Birthplace Denmark

MOTHER
14. Maiden Name Margaret Miller
15. Birthplace Germany

16 (a) Informant Mrs. Nettie Kassakaistis
(b) Address 3329 W. Caton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 31. 1945 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Baltimore Md.

18 (a) Funeral director HENRY SANDER & SONS. INC.
(b) Address North Ave. & Broadway

19 (a) OCT 31 1945 (Date received by Registrar) Williams, M.D. Huntington for

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 28. 1945 at 1.50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 14 1943 to Oct 28 1945. and that I last saw him alive on Oct. 10 1945.

Immediate cause of death	Duration
Cardiac failure.	
Due to Arteriosclerotic Cardiovascular disease	
Due to	several years
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Leonard Yaffe M. D.
Address 3101 W. Baltimore Date signed OCT 29 1945

X

G33717

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

(1937)

G33717

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Mulberry & Payson
(c) Hospital or institution:
West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore Essex
(If outside city or town limits, write RURAL and give town)
(d) Street No. 69 Beverly Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Berta Palm

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Samuel
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1875
8. AGE: Years 70 Months Days If less than one day hr. min.
9. Birthplace Roumania (Town, county, and state)
10. Usual Occupation Home Wife
11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Roumania

MOTHER
14. Maiden Name Not Known
15. Birthplace Roumania

16 (a) Informant Richard Polin
(b) Address 69 Beverly Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-31-45 (month) (day) (year)
(c) Cemetery or crematory
Location Balto Hebrew Cem.

18 (a) Funeral director Jack Lewy Inc
(b) Address 14 E Balto St

19 (a) (Date received by local registrar) OCT 31 1945 (b) Registrar Washington for Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 30 1945 at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/11 1945 to 10/30 1945 and that I last saw her alive on 10/30 1945

Immediate cause of death	Duration
Coronary occlusion	
Myocardial infarction	
Congestive C.V. Failure	
Due to Coronary Thrombosis	
Due to Pulmonary Effusion	
Bilateral pneumonia	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Yes, Pulmonary - well sealed off.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lud W Bredenberg M.D.
Address West Baltimore General Hosp Date signed 10/30/45

(OVER)

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

633718

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

633718 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: John Hopkins Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1002 N. Wolfe ST
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin Richardson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	✓

6 (b) Name of husband or wife Mary Reed Richardson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1921

8. AGE: Years	Months	Days	If less than one day
24			hr. min.

9. Birthplace Odessa, Florida
(Town, county, and state)

10. Usual Occupation Laborer
11. Industry or business Shipyard

FATHER
12. Name Benj Richardson
13. Birthplace Odessa, Florida

MOTHER
14. Maiden Name unknown
15. Birthplace " "

16 (a) Informant Mary Reed Richardson
(b) Address 1002 N. Wolfe St

17 (a) ✓ (Burial, cremation, or removal) (b) Date thereof 11-1-45 (month) (day) (year)
(c) Cemetery or crematory Balto National
Location Balto, Md

18 (a) Funeral director Jr L. Preston Langley
(b) Address 619 Mosher St

19 (a) OCT 31 1945 Huntington, W. Va.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 27 1945, at 6 30 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet Wound of Chest

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Oct 27 1945 5 20 P M.
(b) Where did injury occur Tec Drought & Ashland Ave
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury Shot

23. Signature Robert Lee Fontaine M.D.
Medical Examiner.
Date signed Oct 28 1945

VS 151

633719

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 633719

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 d.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1519 Park Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Sturges

3 (b) If veteran, name war — 3 (c) Social Security Account No.

Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Divorced

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years 65 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace Pa (Town, county, and state)

10. Usual Occupation Relief

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs Gertrude Mc Sorley
(b) Address 1519 Park Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 3-45 (month) (day) (year)
(c) Cemetery or crematory Milton cem
Location Milton Pa.

18 (a) Funeral director Chas Gross & Son
(b) Address Penna Ave (Huntington Williams, M.D. Registrar)

OCT 31 1945 (Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 29, 1945, at 8:10 P.M.

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

If the external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Shtarkus M.D. Medical Examiner,
Date signed October 30, 1945.

633720

48285

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V61

Registered No. 633720

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2006 Druid Hill Ave.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Maria Miles.

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	widowed

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-17-04

8. AGE: Years	Months	Days	If less than one day
41	7	12	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Housemaid
11. Industry or business

FATHER
12. Name George Allen
13. Birthplace Va.

MOTHER
14. Maiden Name Willie E. Johnson
15. Birthplace

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 1, 1945 (month) (day) (year)
(c) Cemetery or crematory Gibbons Mem. Pk.
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. Wm. H. Hilliard
(b) Address 1631 Druid Hill Ave.

19 (a) Date received NOV 3 1945 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 29, 1945 at 11.35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 19.... to 19....
and that I last saw her alive on 10-29 1945

Immediate cause of death	Duration
Uremia	about 6 da.
Myocarditis interstitiemy	
Due to Ontario sclerosis, generalized	unknown
Due to	
Other Conditions Diabetes Mellitus	unknown

(Include pregnancy within 3 months of death)

Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence.....at..... M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?.....While at work?.....
(Specify type of place)
(e) Means of injury.....

23. Signature J. M. Williams M. D.
Address Johns Hopkins Hosp. Date signed Nov 30 45

VS 150

937

correct age is especially important. Physicians; please write the

G33721

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 932

G33721 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2829 Northern Parkway
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 2829 Northern Parkway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie Borchelding

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Charles Borchelding

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10 - 1864

8. AGE: Years 81 | Months 4 | Days 19 | If less than one day ... hr. ... min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation

11. Industry or business At Home

FATHER 12. Name ? Hahn
13. Birthplace Germany

MOTHER 14. Maiden Name Dora Heron
15. Birthplace Germany

16 (a) Informant Chas Borchelding
(b) Address 3312 Moravia Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 1-45 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem City
Location

18 (a) Funeral director Weiner Funeral Home
(b) Address 200 E Oreans St

19 (a) ... (b) ...
(Signature of registrar) Registrar

OCT 31 1945
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 29 1945, at 1:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 4 1942 to Oct 29 1945, and that I last saw her alive on Oct 25 1945.

Immediate cause of death: Chronic myocarditis
Due to 1: myocardial degeneration
Due to:
Other Conditions: atrophic arthritis arteriosclerosis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. V. Harlow M.D.
Address 4706 Harford Road Date signed 10/30/45

Huntington Williams, M.D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G33722

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G33722

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1724 N. Broadway
(c) Hospital or institution: 9 a

(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1724 N. Broadway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Windsor

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Margaret Windsor
6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) 2/22/1879

8. AGE: Years	Months	Days	If less than one day
58	26	6	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Iron Worker
11. Industry or business

FATHER
12. Name Geo W. Windsor
13. Birthplace Md

MOTHER
14. Maiden Name Brazillean Webster
15. Birthplace Md

16 (a) Informant Mrs Lena Webster
(b) Address 1724 N Broadway

17 (a) Burial (b) Date thereof 11/8/37
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Md

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2005 Orleans St

19 (a) (b)
(Date filed by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/25 1937, at 6:30 A M

21. I certify that I took charge of the remains described above, held an Inspection-Inquest thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature R. J. Lehmann M.D.
Medical Examiner.
Date signed 10/29/37

VS 151 Huntington Williams, M.D. (over)

G33723

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √30E

Registered No. G33723

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Mercy Hosp. 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5d.
(e) Length of stay in Baltimore (yrs., mos., or days) 16yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore-2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 612 E. Balto St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

3 (a) **FULL NAME** Michael Hammers

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife.....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan 27, 1900

8. AGE: Years	Months	Days	If less than one day
45	9	2	..... hr. ..... min.

9. Birthplace Penna
(Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business

FATHER
12. Name Pius Hammers
13. Birthplace Box 226, Cairnbrook, Pa.

MOTHER
14. Maiden Name Anna Lucke
15. Birthplace Penna.

16 (a) Informant Robert Monetrie
(b) Address 405 E. Balto St.

17 (a) Burial (b) Date thereof 10/31/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Laurel Heart
Location Berwyn, Hill Rd

18 (a) Funeral director J. Fahey Jones
(b) Address 3 W. Eight St.

19 (a) [illegible] (b) .....
(Date received by local registrar)
Registrar
Huntington Williamsville, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/29 1945, at 7.25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/24 1945, to 10/29 1945, and that I last saw him alive on 10/29 1945.

Immediate cause of death	Duration
Impacted Cardiac Contention	
Due to Lentic C-V- disease	
Due to Aortic Insufficiency	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....
23. Signature Charles Strahan Jr. M.D.
Address Mercy Hosp. Date signed 10/29/45

G33724

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

G33724 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6211 Mosaway,
(c) Hospital or institution: at home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6211 Mosaway
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Ellsworth Lewis

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower
6 (b) Name of husband or wife: Kate E. Lewis
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 16 1861

8. AGE: Years 84 | Months 3 | Days 14 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation none
11. Industry or business none

FATHER
12. Name Stephan H. Lewis
13. Birthplace not known

MOTHER
14. Maiden Name Martha Moore
15. Birthplace not known

16 (a) Informant Mrs Myers Lewis (daughter)
(b) Address 6211 Mosaway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 1 45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville

18 (a) Funeral director Stewart & Co.
(b) Address 108 W Mt Royal

19 (a) OCT 31 1945 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 30 1945, at 12:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 19 1945, to Oct 30 1945, and that I last saw h alive on Oct 29 1945.

Immediate cause of death	Duration
Cerebral hemorrhage	10 da.
Due to Atherosclerosis general & cerebral	10 yrs.
Due to Senility	15 yrs.
Other Conditions Contusion & laceration in fall after senility	10 days

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes fill in the following: Not Accident Suicide or Homicide
(a) Accident, suicide, or homicide
(b) Date of occurrence Oct 19 1945 at 7:00 P.M.
(c) Where did injury occur? 6211 Mosaway (City or town) Balto. (County) Md. (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No.
(e) Means of injury Fell down flight of stairs striking head

23. Signature A. E. Chatfield, M.D.
Address 610 York Rd Date signed Oct 30, 1945
Howard J. Mencken, M.D.

VS 180

Every item of information should be carefully supplied. Write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

G33725 1.43 BALTIMORE CITY HEALTH DEPARTMENT G33725
CERTIFICATE OF DEATH 133B
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address E. Monument St. (Hospital)
(c) Hospital or institution:
Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 18 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Cecil
(c) City or town Elkton Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. Same (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Summers McNell Dean

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 25, 1915

8. AGE: Years 30 | Months 9 | Days 5 | If less than one day hr. min.

9. Birthplace West Virginia (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Edgar Wm. Dean
13. Birthplace W. Va.

MOTHER
14. Maiden Name Pearl Elizabeth Cutlip
15. Birthplace W. Va.

16 (a) Informant Mr. Cecil B. Dean
(b) Address Elkton, Md.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Oct. 31, 1945 (month) (day) (year)
(c) Cemetery or crematory
Location Roncoverte W. Va.

18 (a) Funeral director Wm. J. Tickner & Sons, Inc.
(b) Address North & Pa. Aves.

19 (a) (Signature or initials of registrar) (b) Huntington Nov 1 1945 Registrar

OCT 31 1945
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/30 1945, at 6:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/27 1945, to 10/30 1945, and that I last saw him alive on 10/30 1945.

Immediate cause of death Anemia — Duration

Due to Hydronephrosis

Due to Gall bladder

Other Conditions Hypertension
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alvin D. Rude M. D.
Address Sinai Hosp. Date signed 10/30

Please write the causes of death clearly and legibly. Physicians: please write with ink; avoid abbreviations; correct age is especially important.

X

G33726 BALTIMORE CITY HEALTH DEPARTMENT G33726
CERTIFICATE OF DEATH V 131a
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3015 Fleetwood Av.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3015 Fleetwood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna J Johnson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife George J.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 5 - 1872

8. AGE: Years 73 | Months 4 | Days 27 | If less than one day hr. min.

9. Birthplace Baltimore - Md. (Town, county and state)

10. Usual Occupation at home

11. Industry or business

FATHER 12. Name Edward Keller
13. Birthplace Prussia

MOTHER 14. Maiden Name Dorothea Gerang
15. Birthplace Germany

16 (a) Informant Mrs. Margaret Kerker
(b) Address 1727 N. Wolfe Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-30-45 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Leonard J. Leuck
(b) Address 5305 Harford Rd.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

OCT 31 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 27 19 45 at 4:09 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/20 19 45 to 10/27 19 45 and that I last saw h[er] alive on 10/27 19 45

Immediate cause of death: Cerebral-vascular thrombosis
Due to: Arteriosclerosis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Peter L Sauerbrunn M. D.
Address 1076 S. East Ave Date signed 10/30/45

Kunkowski

G33727

AB-43955

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G33727 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6yrs-6mos-12days
(e) Length of stay in Baltimore (yrs., mos., or days) 56yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2930 Greenmount Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lawrence Armstrong

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1- 1869?

8. AGE: Years	Months	Days	If less than one day
76?	4	29	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business

FATHER
12. Name John Armstrong (D)
13. Birthplace Md. Maney

MOTHER
14. Maiden Name Kelly (D)
15. Birthplace Ireland

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 11-1-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St Joseph Cem.
Location Texas Md
18 (a) Funeral director Bernard J Ruck
(b) Address 5305 Harford Rd
19 (a) (b)
(Date rec'd by registrar) Registrar

OCT 31 1945 Washington Hillsville, Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 30 1945, at 5.50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-18 1939 to 10-30 1945 and that I last saw him alive on 10-30 1945

Immediate cause of death	Carcinoma	Duration
Due to	Ca of thyroid + metastasis	
Due to		
Other Conditions		

(Include pregnancy within 3 months of death)
Date of operation 1933
Major findings of operation: Ca of thyroid + metastasis
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Eugene Adrian Patterson M. D.
Address B.C.H Date signed 10-31-45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Brennan
5217 Harford Road
G33728

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

/98 G33728

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1725 East Lanvale Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town) 16
(d) Street No. 1725 East Lanvale Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Spellman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 23, 1858

8. AGE: Years	Months	Days	If less than one day
87	1	7	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name John J. Spellman
13. Birthplace Ireland

MOTHER
14. Maiden Name Bridget A. Brogan
15. Birthplace Irlenad

16 (a) Informant William B. Miles
(b) Address 1725 E. Lanvale Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-2-45 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) [illegible] (Registered by registrar) (b) Registrar

Huntington Hilleman, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 30, 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 26 1945 to Oct 28 1945 and that I last saw h[illegible] alive on Oct 28 1945

Immediate cause of death	Duration
Arteriosclerosis	
Gangrene.	
Due to	
Due to	
Other Conditions Cachexia	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas Brennan M. D.
Address 5217 Harford Rd Date signed 10-30-45

G33729

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1706

G33729 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 hours
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4331 E. Lombard St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Kressbert

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	?

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years	Months	Days	If less than one day
64			hr. min.

9. Birthplace
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden Name Unknown

15. Birthplace

16 (a) Informant Harvey Rubin

(b) Address 4331 E Lombard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 31 1945 (month) (day) (year)

(c) Cemetery or crematory St. Matthew

Location Edmondson Rd

18 (a) Funeral director Waidell & Keppel

(b) Address 2625 Huntington Ave Baltimore, Md

10 1 1945 (Date filed by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 27 1945, at 2 05 P M

21. I certify that I took charge of the remains described above, held an Partial Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 25/7 30

(a) Date of injury Oct. 27 1945 9 A M.

(b) Where did injury occur Lombard & Kresson Sts.

(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No

(d) Means of injury Pedestrian struck by auto

23. Signature Robert Lee Graham M.D.
Medical Examiner.

Date signed Oct. 29 1945

VS 151

G33730

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157E

G33730 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 1 wk

2. USUAL RESIDENCE OF DECEASED:
(a) State Del (b) County
(c) City or town Masconotah (If outside city or town limits, write RURAL and give town)
(d) Street No. 1035 W Main St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Donna Sue Heacock

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-18-45

8. AGE: Years | Months: 7 | Days: 13 | If less than one day: hr. min.

9. Birthplace Del (town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER 12. Name Donald Heacock
13. Birthplace Wis.

MOTHER 14. Maiden Name Dorothy Schopp
15. Birthplace Del

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/2/45 (month) (day) (year)
(c) Cemetery or crematory Masconotah Cem.
Location Masconotah, Del.

18 (a) Funeral director John D. Mitchell & Sons
(b) Address 1900 Eutaw Place

19 (a) Date received OCT 31 1945 Huntington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 31 1945, at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 28 1945 to Oct 31 1945, and that I last saw him alive on Oct 31 1945

Immediate cause of death: Respiratory failure — Duration: libs

Due to: Congenital heart disease — Duration: 2 days

Due to:

Other Conditions: Staphylococcal septicemia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. E. Morrison Jr. M. D.
Address Johns Hopkins Hosp. Date signed 10/31/45

G33731

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 43a

Registered No. G33731

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2313 Maryland Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2313 Maryland Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary F. Elliott

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Thomas M. Elliott
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 8, 1862

8. AGE: Years	Months	Days	If less than one day
83	7	22	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name Daniel Scully
13. Birthplace Ireland

MOTHER
14. Maiden Name Frances Byrne
15. Birthplace St. Johns, N. F.

16 (a) Informant Mr. T. Donald Elliott
(b) Address 2313 Maryland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 2, 1945 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Baltimore, Md.

18 (a) Funeral director Miller Lamborn
(b) Address 4510 Liberty Heights Ave.

19 (a) 1945 (Filed by registrar) (b) Registrar

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 30 1945, at 12.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-20 1944, to 10-30 1945, and that I last saw her alive on 10-30 1945.

Immediate cause of death	Duration
Apoplexy - Cerebral Hemorrhage	4 days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature McBole M. D.
Address 6014 York Road Date signed 10-31-45

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X

G33732

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G33732

Write the causes of death clearly and legibly. Physicians: please write exact age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1000 Gramby St (If rural give location)
(e) Citizen of foreign country? N (Yes or No)
If yes, name country

3 (a) FULL NAME David Melman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1871

8. AGE: Years	Months	Days	If less than one day
74			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER
12. Name Jacob Melman
13. Birthplace Russia

MOTHER
14. Maiden Name Freda Schlosberg
15. Birthplace Russia

16 (a) Informant Benjamin Melman
(b) Address 4527 Homer Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 1, 1945 (month) (day) (year)
(c) Cemetery or crematory Bnai Israel Cemetery
Location Southern Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) (Date rec'd by registrar) (b) Registrar

Nov 1 1945 vs Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-31-45, at 8:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-28-1945 to 10-31-1945 and that I last saw h.. alive on 10-31-1945

Immediate cause of death: Coronary Thrombosis — Duration

Due to: Coronary Sclerosis

Due to: Degenerative Cardiovascular Disease

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm A. Holbrook, Jr. M. D.
Address Univ. Hosp. Date signed 10-31-45

333733

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1570

Registered No. 333733

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 717 S. PORT ST.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 717 S. PORT ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WALTER WAWRZYNIAK

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	—

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) OCT. 30 /45

8. AGE: Years	Months	Days	If less than one day
			14hr. hr. min.

9. Birthplace BALTIMORE
(Town, county, and state)
10. Usual Occupation —
11. Industry or business

FATHER
12. Name LAWRENCE WAWRZYNIAK
13. Birthplace BALTIMORE

MOTHER
14. Maiden Name ANNA DOMBROWSKI
15. Birthplace BALTIMORE

16 (a) Informant LAWRENCE WAWRZYNIAK
(b) Address 717 S. PORT ST.

17 (a) BURIAL (b) Date thereof Nov. 1/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory HOLY ROSARY
Location BALTIMORE

18 (a) Funeral director Fred H. Ozarowski
(b) Address 1930 EASTERN AV.

NOV 1 1945 Huntingtor Williams MD
(Date received by local registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 30 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-28-45, to 10-30-45, and that I last saw h[illegible] alive on 10-30-45

Immediate cause of death: Cerebral Hemorrhage — Duration: 2 days

Due to: Paralysis of Left Side — 1 day

Due to: Chronic Nephritis — Many years

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M.D.
Address 600 N. Bethune Date signed 10-31-45

X

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G33734

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G33734

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4014 Colborne Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4014 Colborne Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mila Gilbert

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Late Peter Gilbert
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 7, 1872.

8. AGE: Years	Months	Days	If less than one day
73	2	22	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation H.W.
11. Industry or business Own home

FATHER
12. Name Martin J. Rogers
13. Birthplace IReland

MOTHER
14. Maiden Name Anna McCollogh
15. Birthplace Ireland

16 (a) Informant Mrs. Mary M. Rogers,
(b) Address 4014 Colborne Rd.

17 (a) Burial (b) Date thereof Nov. 1/45.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Rd.
18 (a) Funeral director Harry A. Smith
(b) Address 4101 Edmondson Ave.
19 (a) (b)
(Date rec'd by registrar) Registrar

NOV 1 - 1945

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 29 1945, at 8.05 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 18 1944, to Oct 29, 1945 and that I last saw h er alive on Oct. 28, 1945.

Immediate cause of death	Duration
Myocardial infarction	5 days
Due to hypertensive and arteriosclerotic cardiovascular	
Due to disease	y ears
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leonard Yaffe M.D.
M. D.
Address 3101 W. Baltimore Date signed 10/30/45

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

33735

AB-87163

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 123

Registered No. 6337735

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1yr-7mos
(e) Length of stay in Baltimore (yrs., mos., or days) 40yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 30 Albermarle St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Thomas

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?-?-1887?

8. AGE: Years 58 ? | Months | Days | If less than one day: hr. min.

9. Birthplace Sweden (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Dovelais
13. Birthplace Sweden

MOTHER 14. Maiden Name Elizabeth ?
15. Birthplace Sweden

16 (a) Informant Baltimore City Hospitals (Records)
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof: (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School OCT 31 1945
Commissioner of Health

18 (a) Funeral director
(b) Address

19 NOV 1 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 28- 1945, at 3.05P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-28- 1944 to 10-28 1945 and that I last saw him alive on 10-28- 1945

Immediate cause of death	Duration
Coronary occlusion	
Due to Coronary heart disease	2 yrs
Due to (b) Cerebral spastic palsy	
Other Conditions (a) Diverticulitis of colon	

(Include pregnancy within 3 months of death)

Date of operation 10-27-45
Major findings of operation: Diverticulitis-colon
of autopsy: none

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas J Orall M. D.
Address Balto City Hospitals Date signed 10-31-45

PHYSICIAN
Underline the cause to which death should be charged statistically.

Please write the causes of death clearly and legibly. Physicians: please write the cause of death clearly and legibly. Please write the correct age is especially important.

VS 150

3052 X

G33736

AB-12734

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

467

G33736 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28-8- 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) 38yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 919 W. Lombard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fred Bens

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 29- 1874

8. AGE: Years 70 | Months 9 | Days 29 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Peter Bens

13. Birthplace Germany

MOTHER 14. Maiden Name Kate Miller

15. Birthplace Germany

16 (a) Informant Baltimore City Hospitals (Records

(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location University Medical School OCT 31 1945

18 (a) Funeral director Commissioner of Health

(b) Address

19 NOV 1 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 28- 1945, at 6.20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-7- 19 17, to 10-28 1945, and that I last saw h 18 alive on 10-28- 1945

Immediate cause of death Cachexia — Duration

Due to Carcinoma of rectum

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas J O'Neill M. D.
Address Balto City Hospitals Date signed 10-30-45

VS 150

3051

X

G33737

BALTIMORE CITY HEALTH DEPARTMENT

CHK-96771

CERTIFICATE OF DEATH 46E

Registered No. G33737

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 26-12
(d) Length of stay in hospital or inst, (yrs., mos., or days) 5 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. No Home (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Harris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25-1872

8. AGE: Years	Months	Days	If less than one day
72	9	29	hr. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Jim Harris
13. Birthplace North Carolina

MOTHER
14. Maiden Name Sylvia Jones
15. Birthplace North Carolina

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School OCT 31 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 NOV 1 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 24 1945, at 2:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 19 1945 to Oct. 24 1945, and that I last saw h. 1m alive on Oct. 24 1945

Immediate cause of death Cachexia — Duration Wks ?

Due to Carcinoma of Uterus — 1 yr

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas Donnell M. D.
Address Balto. City Hosps Date signed 10-29-45

VS 150

3050

G33738 HEALTH DEPARTMENT—CITY OF BALTIMORE G33738

CERTIFICATE OF DEATH * 107

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. Volunteers of America Hosp. St., Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos 12 ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Patricia Ann Fiddler

If U. S. Veteran specify WAR

(a) Residence: No. Belmont Ave Woodlawn Md St., Ward. Baltimore

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
F	W.	S.

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6. DATE OF BIRTH (month, day, year) 18 Oct 45

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
		12	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. ✓

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Balto Md

FATHER

13. NAME Albie Miller

14. BIRTHPLACE (city or town) (State or country) Balto Md Va.

MOTHER

15. MAIDEN NAME Rosella Arndt

16. BIRTHPLACE (city or town) (State or country) Balto Md

17. INFORMANT Mother

(Address) Belmont Ave Woodlawn

18. BURIAL, CREMATION, OR REMOVAL

Place University Medical School OCT 31 1945

19. UNDERTAKER Commissioner of Health

(Address)

20. FILED NOV 1 1945 21. Huntington Williams M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) 30 Oct, 1945

22. I HEREBY CERTIFY, That I attended deceased from 27 Oct, 1945 to 30 Oct 45

I last saw h alive on 30 Oct 1945 Death is said to have occurred on the date stated above, at 1 30p m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Bronchopneumonia	30 Oct 45
Other contributory causes of importance:	

Was an operation performed? No Date of

For what disease or injury?

Name of operation

What test confirmed diagnosis? Clinical Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or Homicide? Date of injury 19

Where did injury occur?

(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No If so, specify

(Signed) Rosella M.D. M. D.

(Address) Md Pharmacia Hosp.

OCCUPATION is very important. See instructions on back of certificate.

3053 X

G33739

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 477

G33739 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3725 Bonner St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3725 Bonner St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Delbert E Hopkins

3 (b) If veteran, name war —

3 (c) Social Security Account No. 218-07-7918

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Edna H Hopkins

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 1 - 1884

8. AGE: Years 61 | Months 2 | Days 29 | If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Guard

11. Industry or business Crown Cork & Seal

FATHER 12. Name John T. Hopkins

13. Birthplace Md

MOTHER 14. Maiden Name Emily Mears

15. Birthplace Md

16 (a) Informant Mrs Jennie Mae

(b) Address 3725 Bonner St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 2 (month) (day) (year)

(c) Cemetery or crematory Mt Carmel

Location City

18 (a) Funeral director Ullrich Funeral Home

(b) Address 2005 Orleans

19 (a) (Date received by registrar) Huntington Williams

NOV 1 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 31 1945; at 4:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/30 1945 to 10/31 1945 and that I last saw him alive on 10/30 1945

Immediate cause of death Pneumonia Left lung

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Mitchell F. Steuhouse M. D.

Address 1076 S. East 66 Date signed 11/1/45

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G33740

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G33740

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1435 Battery Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1435 Battery Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bessie M. Barnes.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	W.

6 (b) Name of husband or wife George W. Barnes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 2, 1887

8. AGE: Years	Months	Days	If less than one day
58	8	28.	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Housework.
11. Industry or business Home.

FATHER
12. Name Wm. Thos Morrison
13. Birthplace Ireland.

MOTHER
14. Maiden Name Mary O'Rourke.
15. Birthplace Ireland.

16 (a) Informant Family
(b) Address 1435 Battery Ave.

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 11-3-45 (month) (day) (year)
(c) Cemetery or crematory Loudenslager
Location Old Frederick Rd

18 (a) Funeral director James L. McCauley
(b) Address 1400 E. Fort Ave.

19 NOV 1 - 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 30 1945, at 3.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 2 1940, to Oct 30 1945, and that I last saw her alive on Oct 29 1945

Immediate cause of death	Duration
Cardio Vascular Hypertension	5 yrs.
Decard	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dr. H. Barranco M. D.
Address 436 E Fort Ave Date signed 11/1/45

G33741

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G33741 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1701 N. Ellamont Av
(c) Hospital or institution Pemblatte Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1735 Ruxton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bertha R. Howitz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Louis Howitz

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1895

8. AGE: Years 50 | Months | Days | If less than one day hr. min.

9. Birthplace Balto., Md.
(Town, county and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Louis Howitz
13. Birthplace Russia

MOTHER
14. Maiden Name Mary -
15. Birthplace Russia

16 (a) Informant Louis Howitz
(b) Address 1735 Ruxton Ave., Balto.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-1-45 (month) (day) (year)
(c) Cemetery or crematory Sinai Memorial Park
Location

18 (a) Funeral director JCR Lewis Inc
(b) Address 1429 E. Balto. St

19 (a) NOV 1 1945 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-30-45 19 , at 4:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1931 to Oct 22 1945, and that I last saw h alive on Oct 30 1945.

Immediate cause of death Metastatic Carcinoma — Duration

Due to Carcinoma - Intestinal tract

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 2 mos ago - Johns Hopkins

Major findings of operation: Metastatic Carcinoma Hopkins

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature N E Needle

Address 914 N. Mon Date signed 10/31/45 M.D.

N. E. NEEDLE-X

~~33742~~ BALTIMORE CITY HEALTH DEPARTMENT G33742

CERTIFICATE OF DEATH 61

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2002 West Month Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) .....
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2002 West Month Ave
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME MORRIS PEREMEL

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-18-2718

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Bertha –

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years 63 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation Presser

11. Industry or business

FATHER
12. Name Nathan Peremel
13. Birthplace Russia

MOTHER
14. Maiden Name –
15. Birthplace Russia

16 (a) Informant Bertha Peremel
(b) Address 2002 W. North Ave

17 (a) Burial Cremation (b) Date thereof 11-1-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Pinedale
Location .....

18 (a) Funeral director Jacob Weiss Inc
(b) Address 1439 E. Balto. St

19 NOV 1 – 1945 (b) Huntington Williams, M.D.
(Date rec'd by Registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/1/45 19..... at 1:05 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to ..... death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardio Vascular Disease

Due to .....

Other Conditions Diabetes mellitus
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury .....

23. Signature John L. Wade M.D.
Medical Examiner.
Date signed 10/1/45

93

633743

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

633743 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4015 Springdale Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4015 Springdale Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SAMUEL E. BARRON

3 (b) If veteran, name war: 1st World War

3 (c) Social Security Account No. 218-14-5979

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Ida Barron

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-30-1892

8. AGE: Years 53 | Months - | Days 2 | If less than one day ____ hr. ____ min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Pastry Maker

11. Industry or business Wards Bakery

FATHER
12. Name Abraham Barron
13. Birthplace Russia

MOTHER
14. Maiden Name Shurkey —
15. Birthplace Russia

16 (a) Informant Ida Barron
(b) Address 4015 Springdale Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-1-45 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location

18 (a) Funeral director Jack Levin Inc
(b) Address 1431 E. Balto. St

19 (a) [illegible] (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/1/45 19____, at 1:24 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John E. Ward, Medical Examiner M.D.
Date signed 11/1/45

G33744

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G33744

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 Months

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3112 Brentwood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Lewis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Annie
6 (c) If alive, give age 76 years

7. Birth date of deceased (mo., day, yr.) 7-22-1898

8. AGE: Years 47 | Months 3 | Days 5 | If less than one day hr. min.

9. Birthplace Caroline County Virginia
(Town, county, and state)

10. Usual Occupation Porter

11. Industry or business

FATHER
12. Name Walker Lewis
13. Birthplace Caroline County Va.

MOTHER
14. Maiden Name Sallie Taylor
15. Birthplace Caroline County Va.

16 (a) Informant Annie Lewis
(b) Address 329 Ost S.W. Wash. D.C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 2 45 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary Cem.
Location A. A. County Md.

18 (a) Funeral director Mr. Robert A. Elliott & Daughter
(b) Address 1129 N. Caroline St.

19 (a) NOV 1 1945 Registrar
(Date received by Registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH October 29 1945, at 11:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-27 1945 to 10-29 1945 and that I last saw h[illegible] alive on 10-29 1945

Cause	Duration
Immediate cause of death: Cerebral Hemorrhage	
Due to: Hypertension and Cardiovascular disease	
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Douglas Sheppard M.D.
Address Date signed 11/30/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G33745 **HEALTH DEPARTMENT—CITY OF BALTIMORE** G33745

CERTIFICATE OF DEATH 131a

1. **PLACE OF DEATH**

CITY OF BALTIMORE: (No. 3411 Brentwood Ave St., ... Ward)

Registered No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ... yrs. 5 mos. ... da. How long in U. S. If of foreign birth? ... yrs. ... mos. ... da.

2. **FULL NAME** Daniel Owens

If U. S. Veteran specify WAR .....

(a) Residence: No. 3411 Brentwood Ave St., ... Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, year) March 8, 872

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
73 yr.	7	11	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Laborer

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Va.

FATHER

13. NAME Unknown

14. BIRTHPLACE (city or town) (State or country)

MOTHER

15. MAIDEN NAME

16. BIRTHPLACE (city or town) (State or country)

17. INFORMANT Marshall Leverett
(Address) 2453 Brentwood Ave

18. BURIAL, CREMATION, OR REMOVAL
Place South Carolina Date Nov 1 1945

19. UNDERTAKER Mary Gilbert & A. Elliott Dept.
(Address) 1129 N. Caroline St

20. FILED NOV 1 - 1945 ..... Registrar.

OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Oct 29 , 19

22. I HEREBY CERTIFY, That I attended deceased from Sept. 21, 1945 to Oct. 29, 1945

I last saw him alive on Oct. 29, 1945 Death is said to have occurred on the date stated above, at 4:20 A.M.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Myocarditis, with Angina Pectoris, Bronchitis	Aug. 1945

Other contributory causes of importance:

General Arteriosclerosis + Nephritis	Several Years

Was an operation performed? — Date of —

For what disease or injury? —

Name of operation —

What test confirmed diagnosis? — Was there an autopsy? —

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? No Date of injury —, 19

Where did injury occur? —
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place —

Manner of injury —

Nature of injury —

24. Was disease or injury in any way related to occupation of deceased?
No If so, specify —

(Signed) Wm. M. Pennybaker M. D.

(Address) 2740 St. Paul Street Balto.

~~337~~6

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 307

Registered No. 337~~4~~6

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Md.
(c) Hospital or institution: Johns Hopkins Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1230 E. Madison St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Graham

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced,
female	Colored	Seperated

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 27, 1918

8. AGE: Years	Months	Days	If less than one day
27	11	1	hr. min.

26

9. Birthplace Georgia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Moses Bell
13. Birthplace Ga.

MOTHER
14. Maiden Name Otis Johnson
15. Birthplace Ga.

16 (a) Informant Otis Bell
(b) Address 1230 E. Madison St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 1, 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cemetery
Location Q. A. County Md.

18 (a) Funeral director Mrs. Robt A. Elliott Dept
(b) Address 1129 N. Caroline St.

19 (d) NOV 1 - 1945 (Date received by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 28, 1945, at 11:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

Autopsy, Inspection or Inquiry

IMMEDIATE CAUSE OF DEATH Coronary Artial Occlusion

Due to Luetic plague.

Due to Luetic valvulitis and Aortitis.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benjamin Pasternack M.D.
Medical Examiner.
Date signed October 29, 1945.

X

G33747

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G33747

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 345 S. Chester Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 60 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 345 S. Chester Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Skopinski

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Antonina Skopinski
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 9 1883

8. AGE: Years	Months	Days	If less than one day
62	4	19	hr. min.

9. Birthplace South River N. J. (Town, county, and state)
10. Usual Occupation Grocery
11. Industry or business self

FATHER
12. Name John Skopinski
13. Birthplace Poland

MOTHER
14. Maiden Name Unknown
15. Birthplace Poland

16 (a) Informant Mrs Antonina Skopinski
(b) Address 345 S. Chester Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 2 45 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore County

18 (a) Funeral director John Jr. Weber
(b) Address 401 S. Chester Street

NOV 1 - 1945 (Date rec'd by registrar) Hunting for Williams MD (Signature)

VS 150

MEDICAL CERTIFICATION 815

20. DATE OF DEATH Oct 28 1945, at P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 45 to Oct 28 45
and that I last saw him alive on Oct 28 1945

Immediate cause of death	Duration
Coronary Thrombosis	10/28/45
Due to Ch. Myocarditis	1/1945
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William J. Sysauer, M.D.
Address 801 N Kenwood Ave Date signed 10/30/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

33748

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

G33748 ✓ Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dukeland & Raynor.
(c) Hospital or institution:
B.O.A. West Balto. General Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2354 Eutaw Place. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME BERTHA STERN.

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 20, About 1875.

8. AGE: Years	Months	Days	If less than one day
About 70	1	10	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Jacob Stern,
13. Birthplace Germany.

MOTHER
14. Maiden Name Henrietta Fox,
15. Birthplace Germany.

16 (a) Informant Miss. Fannie Stern,
(b) Address 2354 Eutaw Place.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11. 1. 45. (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location Balto. Md.

18 (a) Funeral director Chas. Sonnenstrahl & Son
(b) Address 1902 Eutaw Place.

19 (a) 11-1-1945 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 30th. 1945 at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1945 to Oct 30 1945, and that I last saw h-er alive on Oct 30 1945

Immediate cause of death — Duration
Dilatation of heart (cardiac failure) — (1 mnth
Due to Arteriosclerosis — 8 yrs
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Frederick Lantz M. D.
Address Temple Garden Apts. Date signed Oct 31-45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

633749

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. 633749

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 61 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Temple Garden Apts. (If rural give location)
(e) Citizen of foreign country? U.S. (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mrs. Bertram S. Rice (Cecelia M.)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Bertram S. Rice
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) July 2, 1884

8. AGE: Years	Months	Days	If less than one day
61	3	29	....hr. ....min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Louis Middledorf
13. Birthplace ?

MOTHER
14. Maiden Name Adaline Middledorf
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. B. S. Rice,
(b) Address Temple Garden Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/2/45 (month) (day) (year)
(c) Cemetery ~~crematory~~ Chevra Shalom
Location Balto., Md.

18 (a) Funeral Chevra Sonastrim of Sons
(b) Address 1902 Eutaw place

19 (a) 11-2-1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 31 1945 at 12:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 28 1945 to Oct 31 1945 and that I last saw her alive on Oct 31 1945.

Immediate cause of death	Duration
Cerebro-vascular accident	5 days
Due to Arteriosclerotic heart disease	
Due to	
Other Conditions Diabetes mellitus	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Bayle B. Arnold
Address U. M. H. Date signed 10-31-45 M. D.

93 D

33750

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 84B

Registered No. G33750

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1382 Woodyear
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 11
(e) Length of stay in Baltimore (yrs., mos., or days) 21yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1382 Woodyear Av
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Louise Baptist Daniels

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colrd

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Robert Daniels

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 23, 192x

8. AGE: Years 21 | Months 3 | Days 7 | If less than one day ... hr. ... min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name William Baptist
13. Birthplace Md

MOTHER
14. Maiden Name Marie Jennings
15. Birthplace Md.

16 (a) Informant Mary Baptist
(b) Address 1382 Woodyear Av

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (11/3/45) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. B. Kelson
(b) Address 1303 Pennsman Av.

19 (a) REC'D 1-1545 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 30 19x5, at 8.30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 26 19x5, to Oct 30 19x5, and that I last saw her alive on Oct 29 19x5.

Immediate cause of death Catatonic — Duration 4 months

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William Frey M. D.
Address 1928 Penna Ave Date signed 11/ /45

G33751

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G33751

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 954 - Forrest St.
(c) Hospital or institution: Md. Penitentiary
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1319 W. Stockton St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ernest Wright

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 13, 1915

8. AGE: Years	Months	Days	If less than one day
30	3	18	hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Leon Wright
13. Birthplace Maryland

MOTHER
14. Maiden Name Beatrice Cormish
15. Birthplace Baltimore, Md.

16 (a) Informant Mary Dockett
(b) Address 1319 Stockton St

17 (a) Burial (b) Date thereof 11 3 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md.

18 (a) Funeral director Geo. H. Kelson
(b) Address 1303 Pressman St

19 (a) NOV 1 - 1945 (b) Huntington Williams II
(Date rec'd by registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH October 31 1945, at 8:55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 21 1945 to Oct. 31 1945 and that I last saw him alive on Oct. 31 1945.

Immediate cause of death	Duration
Cerebral hemorrhage	
Due to malignant hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. F. Korns M. D.
Address Medical Arts Bldg Date signed 10-31-45

Benedict Retarski M.D. Asst. Examiner.

Correct age in carefully important. Physicians: please write the causes of death clearly and legibly.

G33752

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124a

Registered No. G33752

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 100 N. Calhoun St.
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 25 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1816 Druid Park Dr. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Frank Cephus

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife Clara
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/5/1906

8. AGE: Years	Months	Days	If less than one day
44	8	26	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Chauffeur
11. Industry or business

FATHER
12. Name Frank Cephus
13. Birthplace Md.

MOTHER
14. Maiden Name Eva Wilson
15. Birthplace Md.

16 (a) Informant Grace Matthews
(b) Address 1308 N. Bruce St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/4/45 (month) (day) (year)
(c) Cemetery or crematory Denton, Md.
Location Md.

18 (a) Funeral director George H. Kelso
(b) Address 1303 Pleasant St.

NOV 1 - 1945 (Date rec'd by registrar) (b) Huntingtown Williams Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/31/1945, at 2:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/30/1945, to 10/31/1945, and that I last saw him alive on 10/31/1945.

Immediate cause of death	Duration
Hemorrhage	
Due to: ruptured esophageal varices	
Due to alcoholic cirrhosis of the liver	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation:
of autopsy: Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Bobby L. Lowe M. D.
Address Franklin Sq. Hosp. Date signed 11-1-45

633753

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

633753 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 656 George St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 656 George St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Jenkins

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex F | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Thomas
6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) 10-1-1889

8. AGE: Years 56 | Months 1 | Days — | If less than one day hr. min.

9. Birthplace Washington D.C. (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Alfred Patty
13. Birthplace D. C.

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Thomas Jenkins
(b) Address 656 George St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-6-45 (month) (day) (year)
(c) Cemetery or crematory ARDUS MEM. C[illegible]
Location Baltimore Md

18 (a) Funeral director William A Jackson
(b) Address 916 Pedra ave

NOV 1 - 1945 (Date rec'd by registrar) (b) Hunting for Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 1 1945 12:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 26 1945 to Nov 1 1945, and that I last saw him alive on Nov 1 1945.

Immediate cause of death	Duration
(a) Arteriosclerotic Cirrh	1 yr
Due to (b) Acute Dilat	
Due to (c)	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 75 W Mt Vernon Pl Date signed 11-1-45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. 33754

33754

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 W. Lexington
(c) Hospital or institution Aged Womens Home

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 10 or More yrs

2. USUAL RESIDENCE OF DECEASED:
(a) No. Md (b) County Balls City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1400 W. Lexington
(If rural give location)
(e) Citizen of foreign country? — No — (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Sarah C. Lytton

3 (b) If veteran, name war: No
3 (c) Social Security Account No. none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sep-12-1868

8. AGE: Years 77 | Months 6 | Days 19 | If less than one day: hr. min.

9. Birthplace Easton Md (Town, county, and state)
10. Usual Occupation none
11. Industry or business none

FATHER 12. Name Thos. H. Edgar
13. Birthplace Maryland

MOTHER 14. Maiden Name Mary Mason
15. Birthplace Maryland

16 (a) Informant Records of Home
(b) Address 1400 W Lexington

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov-1-45 (month) (day) (year)
(c) Cemetery or crematory Spring Hill
Location Easton Md.

18 (a) Funeral director Stuart-Mamon Co.
(b) Address 108 W. North Ave.

19 (a) NOV 1 - 1945 (Date rec'd by registrar) (b) Certificate for Williams MB (Registered)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/1/45 19 , at 3:30 M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/21/ 1935 to 11/1/ 1945.
and that I last saw her alive on 10/21 1945.

	Duration
Immediate cause of death: Coronary insufficiency	Sudden
Due to: Diabetes mellitus	? yrs.
Due to:	
Other Conditions: Generalized arterio-sclerosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Irvin B. Jarrett M. D.
Address 11 E. Chase St. Date signed 11/1/45

VS 150

correct age is especially important. Physicians: please write the

33755

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G33755 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3121 St. Paul St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3121 St. Paul St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GUSTAF A. ANDERSON

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	--Married

6 (b) Name of husband or wife Rachel B. Anderson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 13, 1862

8. AGE: Years	Months	Days	If less than one day
82	10	18	hr. min.

9. Birthplace Sweden
(Town, county, and state)
10. Usual Occupation Engineer
11. Industry or business

FATHER
12. Name Carl Gustaf Anderson
13. Birthplace Sweden

MOTHER
14. Maiden Name Marie Sophie Pausette
15. Birthplace Sweden

16 (a) Informant Mr. G. C. G. Anderson
(b) Address 502 Woodlawn Rd.

17 (a) Removal (b) Date thereof 11/1/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Waynesboro, Pa.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 NOV 1 - 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 31, 1945, at 9:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1927 to Oct. 31 1945, and that I last saw h[illegible] alive on Oct. 30, 1945.

Immediate cause of death: Arteria-sclerosis — Duration: 3 yrs. at least

Due to — Duration: 1 yr.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature N B Eckman M.D.
Address 1041 St. Paul St Date signed 11/1/45

X

3756

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

633756 Registered No.

Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2835 The Alameda
(c) Hospital or institution:

9-6

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2835 The Alameda
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA KLEINSCHMIDT

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Henry Kleinschmidt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 11, 1856

8. AGE: Years	Months	Days	If less than one day
89	8	18	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name John Kirchner
13. Birthplace Germany

MOTHER
14. Maiden Name Maria Bloechner
15. Birthplace Germany

16 (a) Informant Mr. Henry Kleinschmidt
(b) Address 1621 Abbottston St.

17 (a) Burial (b) Date thereof 11/2/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

NOV 1 - 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 29, 1945 at 10:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 23 1945 to Oct 29 1945 and that I last saw h[er] alive on Oct 29 1945.

Immediate cause of death Pneumonia — Duration 5 days
Labar
Due to Myocarditis — 10 days
Interstitial
Due to age.
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ernest L. Cunningham M. D.
Address 2858 Harford Rd Date signed 10-31-45

VS 150

G33757

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G33757 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4211 Massachusetts Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4211 Massachusetts Aye.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ADAM ENGEL

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widow

6 (b) Name of husband or wife Dorothea L. Engel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 11, 1867

8. AGE: Years	Months	Days	If less than one day
78	6	20	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name William Engel
13. Birthplace Germany

MOTHER
14. Maiden Name Christina Fisher
15. Birthplace Germany

16 (a) Informant Mrs. Katherine Nowell
(b) Address 4211 Massachusetts Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/3/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

NOV 1 - 1945 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 31, 1945, at 11 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 25 1945 to Oct. 31, 1945 and that I last saw him alive on Oct. 30, 1945.

Immediate cause of death	Duration
Cerebral hemorrhage & paralysis	6 days
Due to Advanced arterio-sclerosis	?
Due to Myocarditis about	6 mo.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Hratio Dubbert M. D.
Address 2220 Garrison Blvd Date signed 11/1/45

VS 180

33758

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G33758

Please write the causes of death clearly and legibly. Physicians: please write. Exact age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 713 S. Conkling St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) yr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 713 S Conkling St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret M. Westerman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F.

5. Color or race W.

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife C. Alex Westerman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-28-77.

8. AGE: Years 68 | Months 1 | Days 2 | If less than one day hr. min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation House-wife.

11. Industry or business At home.

FATHER 12. Name ? Martins

13. Birthplace Germany

MOTHER 14. Maiden Name Ernestine ?

15. Birthplace Germany

16 (a) Informant Mrs. Marg. Jackson (Daughter)

(b) Address 3814 Hudson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-3-45 (month) (day) (year)

(c) Cemetery or crematory Mt. Carmel Cem.

Location O'Donnell St.

18 (a) Funeral director Charles S. Seiler.

(b) Address 3605 Fait Ave.

19 (a) On 1945 (Date of the registration) (b) Registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 30, 1945, at 4:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 15 1942 to Oct 30 1945 and that I last saw h[er] alive on Oct 29 1945.

Immediate cause of death Diabetes
Arteriosclerosis C.V. Disease
Chronic Nephritis.
Due to Myocardial Failure

Due to

Other Conditions None
(Include pregnancy within 3 months of death)

Date of operation None,

Major findings of operation:

of autopsy: None

Duration
Sept 15/42
Aug 12/45
Oct 1 1945

PHYSICIAN
Underline the cause to which death should be charged statistically.

37. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence None at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Lichtenwalner M.D.

Address 842 Eutaw Date signed Oct. 31-45

VS 180

G-33759

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92E

Registered No. G33759

Please write the causes of death clearly and legibly. Physicians: please write correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1816 WALBROOK AVE.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 yr
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1816 WALBROOK AVE (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CATHERINE A. HERKHOTZ

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. NONE

4. Sex FEMALE | 5. Color or race WHITE | 6 (a) Single, married, widowed, or divorced. WIDOWED

6 (b) Name of husband or wife HENRY G.

6 (c) If alive, give age / years

7. Birth date of deceased (mo., day, yr.) FEB-18-1868

8. AGE: Years 77 | Months 8 | Days 11 | If less than one day — hr. — min.

9. Birthplace BALTIMORE, MARYLAND (Town, county, and state)

10. Usual Occupation HOUSEWIFE.

11. Industry or business HOME

FATHER
12. Name CHRISTIAN TUPP.
13. Birthplace GERMANY

MOTHER
14. Maiden Name ELIZABETH WAGNER
15. Birthplace GERMANY

16 (a) Informant BERTHA H. DOTTERWEICH
(b) Address 1816 WALBROOK AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof NOV. 2-45 (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK.
Location FREDERICK AVENUE

18 (a) Funeral director G. LESTER WEBER
(b) Address 2503 EDMONDSON AVE

19 (a) (Date received by Registrar) NOV 1 1945 (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 29, 1945; at 11P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1940, to Oct. 29 1945, and that I last saw h[illegible] alive on Oct. 24 1945.

Immediate cause of death	Duration
Coronary Thrombosis	4 yrs
Due to Hypocarditis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Abraham Schapiro

Address 2028 Eutaw Pl. Date signed 11-30-45 D.

VS 150

G33760

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G33760

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 21 N. Clinton Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 21 N. Clinton Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN LEWIS MILK

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	212-01-5194

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife Florence Milk
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 27, 1874

8. AGE: Years	Months	Days	If less than one day
70	10	4	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name John Milk
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Mary B. Kolb
15. Birthplace Germany

16 (a) Informant Mr. Paul H. Milk
(b) Address 37 S. East Avenue

17 (a) Burial (b) Date thereof 11-2-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Fifth German Reformed
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 NOV 1 - 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 31 1945, at 4 a M

21. I certify that death occurred on the date above stated; that I attended deceased from April 7 1945, to Oct. 31 1945, and that I last saw him alive on Oct 30 1945

	Duration
Immediate cause of death: myocardial insufficiency	4 days
Due to: cachexia, general carcinomatosis	
Due to: adeno-carcinoma of ascending colon.	?
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation June 1945
Major findings of operation: adeno-carcinoma ascending colon.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature L. C. Sothiral M.D.
Address 4474 Kenwood Ave. Date signed Oct 31 45

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G33761

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓171a

Registered No. G33761

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Md.
(c) Hospital or institution: South Baltimore Gen'l. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1013 Peach Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Amelia A. Harmon

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1895

8. AGE: Years	Months	Days	If less than one day
50	3		hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name John Horsey
13. Birthplace Md

MOTHER
14. Maiden Name Elenor Brisco
15. Birthplace Md

16 (a) Informant Mary Fadan
(b) Address 528 W Cross St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 11-2-45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Balto. Co. Md.

18 (a) Funeral director Joseph L Brown & Son
(b) Address 108 W Montgomery St

19 (a) NOV 1 1945 (Date received by local registrar) (b) Signature for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 28, 1945, at 5:20 P. M.

21. I certify that I took charge of the remains described above, held an Partial Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Compound Skull Fracture.
Laceration of the brain.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-28-45 at 5 P. 23/1 M.
(b) Where did injury occur? Hamburg & Leadenhall Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No.
(d) Means of injury Pedestrian struck by streetcar.

23. Signature Benedict Skotarelis M.D. Medical Examiner.
Date signed October 29, 1945

VS 151

G33762 HEALTH DEPARTMENT—CITY OF BALTIMORE G33762

CERTIFICATE OF DEATH √ 430

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1202 Young Court St., ... Ward)

Registered No. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ... yrs. ... mos. ... da. If not in U. S. If of foreign birth? ... yrs. ... mos. ... da.

2. FULL NAME Georgianna Butler S

If U. S. Veteran specify WAR .....

(a) Residence: No. 1202 Young Ct. St., ... Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

3a. If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6. DATE OF BIRTH (month, day, year) Dec. 25, 1873

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
71 Yrs	10	4	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Domestic

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. .....

10. Date deceased last worked at this occupation (month and year) .....

11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (city or town) (State or country) St. Mary's County

FATHER

13. NAME Unknown

14. BIRTHPLACE (city or town) (State or country) .....

MOTHER

15. MAIDEN NAME Teresa Parr

16. BIRTHPLACE (city or town) (State or country) St. Mary's County

17. INFORMANT Eleanor Vincent

(Address) 1202 Young's Court.

18. BURIAL, CREMATION, OR REMOVAL

Place St Peters Cem. Date Nov 3 1945

19. UNDERTAKER Mr. Robert G Elliot - Dft.

(Address) 1159 N. Caroline St.

20. FILED NOV 1 - 1945 Huntington Williams M.D.
Registrar.

OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Oct 29 1945

22. I HEREBY CERTIFY, That I attended deceased from 26 Oct 1945 to 29 Oct 1945

I last saw her alive on 28 Oct 1945. Death is said to have occurred on the date stated above, at 7 P m.

The principal cause of death and related causes of importance were as follows:

	Duration between onset and death
Cerebral Apoplexy	3
Hypertension Malignant	5

Other contributory causes of importance:

Was an operation performed? No Date of .....

For what disease or injury? .....

Name of operation .....

What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ..... 19...

Where did injury occur? .....
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place .....

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? N.D. If so, specify .....

(Signed) Albert E. Burrell M. D.

(Address) 171 Presquile St.

X BURRELL

V8 3

633763

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 633763

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State N.J. (b) County
(c) City or town Port Norris
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME
Kinsey, Noah

3 (b) If veteran, name war

3 (c) Social Security Account No. 152-16-0351

4. Sex: M

5. Color or race: Col

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 12, 1922

8. AGE: Years 22 | Months 10 | Days 19 | If less than one day hr. min.

9. Birthplace Lyons, Ga.
(Town, county, and state)

10. Usual Occupation oysterman

11. Industry or business

FATHER
12. Name W.L. Kinsey
13. Birthplace Lyons, Ga.

MOTHER
14. Maiden Name Queen Amy Nails
15. Birthplace Lyons, Ga.

16 (a) Informant Records
(b) Address US Marine Hospital, Balto, Md.

17 (a) Removal (b) Date thereof Nov 2/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Medalia Georgia

18 (a) Funeral director Mrs. Robert O. Elliott Dft
(b) Address 1129 N. Carlisle St.

19 (a) NOV 1 - 1945 (b) Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 31 1945, at 7:30AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 13 1945, to Oct. 31 1945, and that I last saw him alive on Oct. 31 1945

	Duration
Immediate cause of death Pericarditis, acute, hemorrhagic; etiology undetermined	3 wks
Due to tuberculous with serosanguineous effusion.	
Due to Tuberculous pleurisy with pos effusion, left	
Other Conditions: Lymphadenitis, tracheobronchial lymph nodes, left (tuberculous) pericardial	

Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Neil Callahan M.D.
Address Neil Callahan, PA Surgeon Date signed 11/1/45
US Marine Hospital, Balto, Md.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G33764

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

126

G33764 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline Cont.
(c) Hospital or institution:
St. Joseph's Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Fullerton, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Old Philadelphia Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William E. House

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	Wid.

6 (b) Name of husband or wife Emma E. House
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 16, 1875

8. AGE: Years	Months	Days	If less than one day
70	9	15	hr. min.

9. Birthplace Hampden, Md.
(Town, county, and state)
10. Usual Occupation Retired Asst Engineer
11. Industry or business Edgewood Arsenal

FATHER
12. Name Unknown
13. Birthplace Unknown.

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown.

16 (a) Informant Margaret M. Scott.
(b) Address 3114 Remington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 3/45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Memorial Park
Location Taylor Ave

18 (a) Funeral director Chenowith & Donovan
(b) Address 3615-17 Chestnut Ave

19 (a) Nov 1 1945 (Date received by registrar) (b) Huntington Willis, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-31-45 19 at 8:40 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/20/45 19 to 10/31/45 19, and that I last saw him alive on 10/31/45 19

Immediate cause of death

Terminal Pneumonia (Lobar)

Due to Emphysema, Lung abscess & sub-diaphragmatic abscess.

Due to Stone in the common duct.

Other Conditions abd. adhesions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Huntington Willis M. D.
Address St. Joseph's Hosp. Date signed 10-31-45

VS 180

633765

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 633765 / 179a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5625 Groene Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry H. Kidd

3 (b) If veteran, name war

3 (c) Social Security Account No.

Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Caroline Kidd

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 23 1860

8. AGE: Years	Months	Days	If less than one day
85	1	7	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Balto City

FATHER
12. Name Benjamin Kidd
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Dowling
15. Birthplace Maryland -

16 (a) Informant Thomas B. Kidd
(b) Address 3501 Elm Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-2-45 (month) (day) (year)
(c) Cemetery or crematory Prospect Hill
Location Towson Maryland

18 (a) Funeral director Ehrenfeldt & Donovan
(b) Address 3615-17 Chestnut Ave

19 (a) (Date rec'd by registrar) NOV 1 1945 (b) Huntington Williams, Jr. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 30, 1945 at 7:15 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arsenic poisoning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-29-45 P. M.
(b) Where did injury occur? Chas. & Lakewood Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Farm While at work? No
(d) Means of injury Accidental Drinking Wood Alcohol

23. Signature Benedict Stutaker M.D. Medical Examiner.
Date signed October 31, 1945.

633766

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. 633766

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1020 W 38th St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1020 W 38th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Howard S. Hare

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	white	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 3 1869

8. AGE: Years	Months	Days	If less than one day
76	9	26	hr. min.

9. Birthplace Maryland.
(Town, county, and state)

10. Usual Occupation Night Watchman

11. Industry or business Floyd Mitchell

FATHER
12. Name George Hare.
13. Birthplace Maryland.

MOTHER
14. Maiden Name Maria Monroe
15. Birthplace Maryland.

16 (a) Informant Mrs. Maxine Shaffer.
(b) Address 1020 W 38th St.

17 (a) Burial (b) Date thereof Nov 1 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Grave Run
Location Carroll Co Md.

18 (a) Funeral director Chenoweth & Donovan
(b) Address 3611-17 Chestnut Ave

19 (a) NOV 1 - 1945 Hunting for Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 29 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1941 to Oct 29 1945 and that I last saw h/M alive on Oct 29 1945.

Immediate cause of death	Duration
Cerebral Hemorrage	5 days
Due to Hypertension CVD	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Laurance J. Hemauer M.D.
Address 3411 Dallas St Date signed 6-31-45
M. D.

VS 150

633767

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. 633767

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5313 Edmondson Ave.
(c) Hospital or institution:
Mrs. Woods Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Yr.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ---
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4834 Park Heights Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Anna Baker

3 (b) If veteran, name war ---

3 (c) Social Security Account No. ---

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Wht.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 22, 1876

8. AGE: Years	Months	Days	If less than one day
69	--	9	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Elijah Baker
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Eleanore V. McGee
15. Birthplace Balto. Md.

16 (a) Informant Miss. Minnie T. Baker
(b) Address 2704 Garrison Blvd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 3, 1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md.

18 (a) Funeral director George W. Little
(b) Address 2700 Edmondson Ave.

19 NOV 1 - 1945 (Date rec'd by registrar) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 31 1945 at 10 15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 30 1945 to Oct 31 1945
and that I last saw her alive on Oct 31st 1945

Immediate cause of death	Duration
Edema of lungs	24 hrs.
Due to Bronchopneumonia	3 days
Due to Arteriosclerosis & Senility	10 yrs.
Other Conditions Parkinson's Disease	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Geo. E. Watts M. D.
Address 4100 Edmondson Ave Date signed 11/1/45

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

633768

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 633768

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) DOA

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 101 West Monument
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM TALBOTT CHILDS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Ella R. Klinefelter

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 5, 1878

8. AGE: Years 66 67 | Months 11 | Days 25 | If less than one day ... hr. ... min.

9. Birthplace Balto. Co. Md.
(Town, county, and state)

10. Usual Occupation Investment Banker

11. Industry or business

FATHER
12. Name Joshua Childs
13. Birthplace Balto. Co. Md.

MOTHER
14. Maiden Name Sarah Forsythe
15. Birthplace Balto. Co. Md.

16 (a) Informant Mrs. Wm. F. Childs Jr.
(b) Address 4106 Boarman Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/2/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Green Mount
Location Balto. Md.

18 (a) Funeral director John D. Mitchell Funeral
(b) Address 1900 Eutaw Place.

NOV 1 - 1945 (Date rec'd by registrar) (by ... for William ...)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/30/45 19... at 3:20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis, M.D.
Medical Examiner.
Date signed 10/30/45

VS 151

633769

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

126

Registered No. 633769

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Colorado County.....
(c) City or town Montrose (If outside city or town limits, write RURAL and give town.)
(d) Street No. 605 N. First St. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Eugene Jones Carrington

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Katie L.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-11-86

8. AGE: Years 59 | Months 2. | Days 20 | If less than one day ..... hr. ..... min.

9. Birthplace Miss (Town, county, and state)

10. Usual Occupation Garage

11. Industry or business

FATHER
12. Name Eugene Carrington
13. Birthplace Va

MOTHER
14. Maiden Name Cecelia Cocke
15. Birthplace Miss.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof Nov. 4/45 (month) (day) (year)
(c) Cemetery or crematory Montrose Colorado
Location Montrose County

18 (a) Funeral director John [illegible] Von Cobb
(b) Address 1900 Eutaw Place

19 (a) NOV 1 - 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION 15

20. DATE OF DEATH Oct 31 1945 at 5 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 21 1945 to Oct 31 1945 and that I last saw him alive on Oct 31 1945

Immediate cause of death	Duration
Shock	
Due to Hemorrhage	
Due to Operative procedure	
Other Conditions Biliary Cirrhosis Cholelithiasis (Include pregnancy within 3 months of death)	

Date of operation Oct 31 1945
Major findings of operation: Biliary Cirrhosis, Cholelithiasis
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M.
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....

23. Signature Bruce D. Tracy M.D.
Address Johns Hopkins Hosp. Date signed 10/31/45

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G33770

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. G33770

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3501 Callaway Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3501 Callaway Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Laura Jane Faulkner

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-01-6418

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Milton Thomas Faulkner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 2, 1872

8. AGE: Years	Months	Days	If less than one day
72	10	29	hr. min.

9. Birthplace York County, Pa.
(Town, county, and state)
10. Usual Occupation Saleslady
11. Industry or business Bakery

FATHER
12. Name John P. Grissinger
13. Birthplace Lewisberry Pennsylvania

MOTHER
14. Maiden Name Sarah Jane Benedict
15. Birthplace Lewisberry, Pa.

16 (a) Informant Mrs. Ellen B. Kunkel
(b) Address 3501 Callaway Ave.

17 (a) Burial (b) Date thereof Nov. 4, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Emanuel Cemetery
Location Lewisberry, Pa.

18 (a) Funeral director Willis Lawrence
(b) Address 4510 Liberty Heights Ave.

NOV 1 - 1945 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 31 1945 at 1.30A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-1-V 1943 to 10-31 1945 and that I last saw her alive on 10/31 1945

Immediate cause of death: Acute Cardiac Failure — Duration 2 hr

Due to: Right Hemiplegia — Duration 3yr

Due to: Arteriosclerosis Cardiovascular Disease

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph G. Curtis M. D.
Address 678 Washington Blvd Date signed 10/31/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

633771

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

633771 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Md.
(c) Hospital or institution: Provident Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1629 Carey Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Gladden

3 (b) If veteran, name war

3 (c) Social Security Account No.

Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 28, 1921

8. AGE: Years	Months	Days	If less than one day
24	1	3	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Arthur Gladden
13. Birthplace Maryland

MOTHER
14. Maiden Name Eleanor Cynthia
15. Birthplace Maryland

16 (a) Informant Eleanore Gladden
(b) Address 1629 Carey St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/5/45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location md.

18 (a) Funeral director Geo. S. Kelso
(b) Address 1303 Westmoor St.

19 NOV 1 - 1945 (Date rec'd by Registrar) (b) Hunting for Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 31, 1945, at 11:50 M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Gunshot wounds, Head, heart, abdomen, Both elbow and buttocks.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-31-45 at 10:50 P. M.
(b) Where did injury occur? Manhattan Club Pennsylvania Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Public. While at work? No.
(d) Means of injury Shooting.

23. Signature Benedict Skitarelic M.D. (Medical Examiner)
Date signed November 6 1945.

VS 151

G33772

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1794

G33772

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: Provident Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Spartas
(If outside city or town limits, write RURAL and give town)
(d) Street No. ..... (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Everett Vernon Whyte

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife —

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 10/21/45

8. AGE: Years — | Months — | Days 11 | If less than one day ..... hr. ..... min.

9. Birthplace Provident Hospital Md
(Town, county, and state)

10. Usual Occupation City —

11. Industry or business —

FATHER 12. Name Vernon Whyte
13. Birthplace Sparks, Md.

MOTHER 14. Maiden Name Ruth Jackson
15. Birthplace Sparks, Md.

16 (a) Informant Vernon Whyte
(b) Address Sparks, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 2 45 (month) (day) (year)
(c) Cemetery or crematory St. Lukes
Location Hereford, Monkton, Md.

18 (a) Funeral director Laudon W. Brooks
(b) Address Sparks, Md

19 (a) ..... (b) at ..... Registrar
(Date received by Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 1 1945, at 2 05 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute dilatation

.....

.....

Due to Sodium Chloride

.....

Other Conditions .....

.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Oct. 30 1945 at ? M.
(b) Where did injury occur? Sparks
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? Not formula
(d) Means of injury Salt instead of sugar put in

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Nov. 1st 1945

X

633773

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170 c

Registered No. 633773

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2605 Maenpel Lane (If no street address, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Jacob Zill

3 (b) If veteran, name war None — 3 (c) Social Security Account No. None

4. Sex: Male — 5. Color or race: White — 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Katherine Zill

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 12, 1872

8. AGE: Years	Months	Days	If less than one day
73	5	19	hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Tinsmith

11. Industry or business Retired

FATHER — 12. Name Unknown

13. Birthplace Germany

MOTHER — 14. Maiden Name Unknown

15. Birthplace Germany

16 (a) Informant Charles J. Zill

(b) Address 2691½ W. Eutaw

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-3-45 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Baltimore, Md.

18 (a) Funeral director George L. Schwab

(b) Address 2101 Frederick Ave.

19 (a) Date received (Registrar) NOV 1 1945 (b) Registrar Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 31, 1945 at 7:30 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Skull,

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-29-45 at 6:20 P. M. 21/5
(b) Where did injury occur? Wilkens Ave. & Brunswick Street
(c) Did injury occur at home, on farm, industrial place, in public place? Public. While at work? No.
(d) Means of injury Pedestrian struck by auto.

23. Signature Robert L. Feather M.D.
Medical Examiner.
Date signed October 31, 1945

G33774

481283

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1190

Registered No. G33774

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 921 N. Eden St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Richardson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-1-45

8. AGE: Years	Months	Days	If less than one day
		24	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Tamer 4 ittr
13. Birthplace

MOTHER
14. Maiden Name Katie Richardson.
15. Birthplace N. C.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical Schoo NOV 1 1945

18 (a) Funeral director Commissioner of Health
(b) Address

NOV 2 1945 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 24 1945, at 6. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1. 1945 to Oct 24 1945, and that I last saw him alive on Oct. 24 1945.

Immediate cause of death	Duration
Dehydration	
Due to Diarrhea + vomiting	2½ wks
Due to	
Other Conditions Prematurity	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Johns Hopkins Hosp. Date signed 10/29/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

3054

X

G33775 ✓ G33775

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157 B

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: union memorial Hosp. 13-8
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 min
(e) Length of stay in Baltimore (yrs., mos., or days) 30 min.

2. USUAL RESIDENCE OF DECEASED:
(a) State md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3858 Falls Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Dorsey. G 35912

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Fe | 5. Color or race white | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-21-45

8. AGE: Years | Months | Days | If less than one day 0 hr. 30 min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name Thomas Dorsey.
13. Birthplace Balto. Md

MOTHER 14. Maiden Name Alice Bourne
15. Birthplace Balto, Md.

16 (a) Informant History.
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Body disposed of by hospital
Location

18 (a) Funeral director
(b) Address

CRV (a) 2-1945 (Date received by Registrar) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 21, 19 45 at 3 20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 21 19 45 to Oct 21 19 45.
and that I last saw he alive on 10-21 19 45.

Immediate cause of death Congenital deformity of spine Spina Bifida. — Duration
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John D. Morris M. D.
Address 1401 E. Eager St Date signed 10-21-45

633776

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

159

Registered No. 633776

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Union memorial Hospital 33rd street
(c) Hospital or institution: Union memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 days
(e) Length of stay in Baltimore (yrs., mos., or days) 38 days.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Cecil
(c) City or town Elkton
(If outside city or town limits, write RURAL and give town)
(d) Street No. RFD #5
(If rural give location)
(e) Citizen of foreign country? O (Yes or No)
If yes, name country

3 (a) FULL NAME Dwight Charles Potts

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife O

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/21/45

8. AGE: Years	Months	Days	If less than one day
	1	38	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation O

11. Industry or business

FATHER
12. Name William Elmer Potts
13. Birthplace Maryland.

MOTHER
14. Maiden Name Anna Logan
15. Birthplace Maryland.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Deposited by Hoffman

18 (a) Funeral director
(b) Address

19 (a) NOV 2 - 1945 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 28 1945, at 9 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/9 1945 to 10/28/1945 and that I last saw h.i.m. alive on 10/28 1945.

Immediate cause of death Cardiac failure — Duration

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation O

Major findings of operation: O

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Mary Raynard Shields M. D.
Address Date signed

Mc GLYN

G33777

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G33777

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 248 S.CONKLING ST.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 D
(e) Length of stay in Baltimore (yrs., mos., or days) 10 YEARS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 248 S.CONKLING ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LAURA R. McGLYN

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.: NONE

4. Sex: FEMALE

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: WIDOW

6 (b) Name of husband or wife: OWEN McGLYN

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): OCT. 5 1879

8. AGE: Years: 66 Months: 0 Days: 26 If less than one day: hr. min.

9. Birthplace: HARFORD CO. MD.
(Town, county, and state)

10. Usual Occupation: HOUSE WIFE

11. Industry or business: AT HOME

FATHER
12. Name: EDWARD BURKINS
13. Birthplace: MD.

MOTHER
14. Maiden Name: ROSE McGIVNEY
15. Birthplace: MD.

16 (a) Informant: ELIZABETH McGLYN (DAUGHTER)
(b) Address: 248 S.CONKLING ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof NOV. 3/45 (month) (day) (year)
(c) Cemetery or crematory: DARLINGTON
Location: DARLINGTON MD.

18 (a) Funeral director: Leilly & Zeiler inc.
(b) Address: 403 S. WOLFE ST.

19 NOV 2 - 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: OCT. 31 1945 at 2 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-27 1944, to 10-31 1945, and that I last saw h-er alive on 10-30 1945

Immediate cause of death	Duration
Coronary Thrombosis	18 Months
Due to chr myocarditis	"
generized arterio sclerosis	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: M. J. Davidow M. D.
Address 3218 Eastern ave Date signed 11-4-45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G33778 ✓ G33778

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County ——
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1331 Shields place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wm Russell Christopher

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Eliza

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1893

8. AGE: Years: 52 | Months | Days | If less than one day: hr. min.

9. Birthplace: Caroline County, Va. (Town, county, and state)

10. Usual Occupation: Laborer

11. Industry or business

FATHER
12. Name [illegible]
13. Birthplace

MOTHER
14. Maiden Name [illegible]
15. Birthplace

16 (a) Informant: Eliza Christopher
(b) Address 1331 Shields Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 6 45 (month) (day) (year)
(c) Cemetery or crematory: Arbutus Mem Park
Location: Arbutus Md

18 (a) Funeral director: William A Jackson
(b) Address: 916 Pemba ave

19 (a) (Date received by registrar) Huntington Williams M.D. Registrar

NOV 2 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 31 1945, at 3.05 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-28 1945 to 10-31 1945, and that I last saw him alive on 10-31 1945

Immediate cause of death: Hepatic insufficiency — Duration: 4-5 weeks (history)

Due to: Metastatic carcinoma

Due to: Bronchogenic carcinoma

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.

Address [illegible] Date signed 11/5

× [illegible]

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

~~33779~~

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48 B ✓

Registered No. 33779

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Lundenmann
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3515 Horton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARION M. GRAVES

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband ~~wife~~ Edward L.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 21, 1896

8. AGE: Years	Months	Days	If less than one day
48	10	10	hr. min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Albert P. Bohling
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Barbara Erickson
15. Birthplace Balto

16 (a) Informant Wilson & Weber
(b) Address 1 W Bradford St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/7/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Wilson, Johnson
(b) Address 2400 E Lan St

NOV 2 – 1945 Date rec'd by Local Registrar Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/31 1945, at 1:20 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/19 1945 to 10/31 1945, and that I last saw h~~er~~ alive on 10/30 1945.

Immediate cause of death	Duration
Carcinoma Thoracis	
Due to Carcinoma of Uterus +	
Due to Metastatic Carcinoma of Bowel + Lungs	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Carcinoma of Uterus + bowel

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dudley Phillips M.D.
Address Md. General Hosp. Date signed 10/31/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 190

X

G33780

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 112

Registered No. G33780

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dakeland & Raynor Sts
(c) Hospital or institution:
West Baltimore General Hosp 15 to
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 13yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1807 Poplar Grove St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Virginia W. Dorney

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 218-10-6792

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife: Harry S. Dorney

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 20, 1895

8. AGE: Years 50 | Months 4 | Days 11 | If less than one day ... hr. ... min.

9. Birthplace Whitemarsh, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Samuel Whitmore
13. Birthplace Md.

MOTHER
14. Maiden Name Emma Hastings
15. Birthplace N. Y.

16 (a) Informant Mrs. Herbert Crose
(b) Address 3134 Presstman St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/3/45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (Date received by registrar) NOV 2 - 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-31 1945 at 1:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-22 1945 to 10-31 1945 and that I last saw her alive on 10-31 1945.

Immediate cause of death: Acute Left Ventricular Dilatation — Duration
Due to: Myocardial Fatigue
Due to: Asthma
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benjamin Breckenridge M. D.
Address West Balto Gen'l Hosp Date signed 10/31/45

VS 150

PLEASE WRITE PLAINLY, with pen and ink. Fill in all blanks. Be sure and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G33781

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G33781 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5023 St. Georges Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-10
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5023 St. Georges Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH P. GREEN

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 215-10-1014

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Stella B. Green

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 31, 1880

8. AGE: Years	Months	Days	If less than one day
65	4	0	hr. min.

9. Birthplace Renova, Pa. (Town, county, and state)

10. Usual Occupation Inspector

11. Industry or business War Shipping Adm.

FATHER
12. Name Joseph P. Green
13. Birthplace Reading, Pa.

MOTHER
14. Maiden Name Emma Eisenho
15. Birthplace Reading, Pa.

16 (a) Informant Mrs. Stella B. Green
(b) Address 5023 St. Georges Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11/3/45 (month) (day) (year)
(c) Cemetery or crematory Northbend Cem.
Location Renovo, Pa.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 2 - 1945 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 31, 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to Oct 30 1945 and that I last saw h alive on Oct 30 1945

Immediate cause of death Heart Block — Duration 15 min

Due to Coronary Sclerosis — Duration 9

Due to — Duration

Other Conditions Hypertension — Duration 2 yrs.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward Brownstead M. D.
Address 3136 Hereford Rd (Date signed) 11/1/45

VS 150

X

G33782

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1600

Registered No. G33782

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: W.B.D.H. 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balt
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3206 Haywood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Shaffer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: W.

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 26, 1945

8. AGE: Years | Months | Days: 5 | If less than one day: hr. min.

9. Birthplace W. B. D. H.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Harold Eugene Shaffer
13. Birthplace Pa.

MOTHER
14. Maiden Name Verna Tudley
15. Birthplace Md

16 (a) Informant Harold E. Shaffer
(b) Address 3206 Haywood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-2-45 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director Ellis S. White
(b) Address 2248 W. Baltimore St.

19 NOV 2 - 1945 (Date received by Registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 31 1945, at 3:15 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 26 1945 to Oct 31 1945 and that I last saw him alive on Oct 26 1945

Immediate cause of death	Duration
Asthelectasis	
Due to Intracranial Hemorrhage	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. Fehrenbach M.D.
Address West Balt. Gen. Hosp. Date signed 10/31/45

VS 150

Please write the cause of death clearly and legibly. Physicians: please write, correct age is especially important.

G33783

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G33783

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2900 Springhill Ave
(c) Hospital or institution: 15-12
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2900 Springhill Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie Rosenfeld

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Louis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years 59 | Months | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER
12. Name Harry Poland
13. Birthplace

MOTHER
14. Maiden Name Sarah
15. Birthplace Poland

16 (a) Informant Samuel Rosenfeld
(b) Address 2900 Springhill ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-2-45 (month) (day) (year)
(c) Cemetery or crematory Windsor Mill Rd.
Location

18 (a) Funeral director Jack Levin Inc
(b) Address 1739 E. Baltimore St

19 NOV 2 - 1945 (date received by registrar) Huntington Williams M.R.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-1 1945 at 7A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1941 to 11/1 1945 and that I last saw h[illegible] alive on 11/1 1945

Immediate cause of death Pulmonary Edema — Duration 1 hr.

Due to Cardiac Failure — 3-4 mos.
Cardiac Hypertension
Due to Arteriosclerosis Hypertension

Other Conditions Diabetes Mellitus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hudson Cooper
Address 7201 Eastern Place Date signed 11/1/45

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians:

633784

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

√1310

Registered No. 633784

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2516 Quantico Ave.,
(c) Hospital or institution:

15-13

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 57 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2516 Quantico Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Isaac Morowitz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Lena

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years 73 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Ret.

11. Industry or business

FATHER
12. Name Joseph B. Morowitz
13. Birthplace Russia

MOTHER
14. Maiden Name Bough -
15. Birthplace Russia

16 (a) Informant Miss Mollie Morowitz
(b) Address 2516 Quantico Ave.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-2-45 (month) (day) (year)
(c) Cemetery or crematory Hebrew Sinai Cem
Location Jos Levine Inc

18 (a) Funeral director
(b) Address 1431 E. Balto. St

19 (a) (Date received by Registrar) (b) Registrar

NOV 2 1945 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-31-45 19 at 1 15 P. M

21. I certify that death occurred on the date above stated, that I attended deceased from 1/10 1938 to 10/31 1945, and that I last saw him alive on 10/31 19 45.

Immediate cause of death Bronchopneumonia

Due to arteriosclerosis

Due to Chronic nephritis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature David Greenberg M. D.
Address 1111 Lee Date signed 11/1/45

correct age is especially important. Physicians: please write the

X

G33785 VINCENT DIGIORGIO

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G33785

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd and Calvert Sts.
(c) Hospital or institution: Union Memorial Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) unknown

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3808 Frenchurch
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Di Giorgio, Mr. Vincent

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Mrs. Vincent Di Giorgio
6 (c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) 12/26/1869

8. AGE: Years	Months	Days	If less than one day
75	10	5	..... hr. ..... min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Salvatore Di Giorgio
13. Birthplace Italy

MOTHER
14. Maiden Name Concetta Zalca
15. Birthplace Italy

16 (a) Informant Brother-in-law nurse
(b) Address unknown

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 3-45 (Month) (day) (year)
(c) Cemetery or crematory New Cath. Old Frederick Rd.
Location
18 (a) Funeral director John A. McGraw
(b) Address 3610 E. Baltimore St.
19 (a) Nov 2 - 1945 (Date received by registrar) Huntington Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 31 1945, at 6:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 27 1945 to Oct. 31 1945, and that I last saw him alive on Oct. 31 1945

Immediate cause of death Uremia — Duration

Due to Arteriosclerotic heart disease, & decompensation

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Crawford N. Kilpatrick, Jr. M. D.
Address Union Memorial Hosp. Date signed 10-31-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 130

G33786

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G33786 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6621 O'Donnell Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6621 O'Donnell Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William F. Lusk

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Frances Lusk
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 16, 1853

8. AGE: Years	Months	Days	If less than one day
82	5	15	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Tavern Keeper
11. Industry or business

FATHER 12. Name	Joseph Lusk
13. Birthplace	Germany
MOTHER 14. Maiden Name	Not Known
15. Birthplace	Germany

16 (a) Informant Wm. F. Lusk
(b) Address 6621 O'Donnell St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-3-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto Md

18 (a) Funeral director Thos. Gracchas
(b) Address 900 E. Chester St

19 NOV 2 — 1945 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/1/45 19..., at 7:30 AM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Coronic Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis, M.D. Medical Examiner.
Date signed 11/1/45

G33787 Bobby ✓ G33787

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170c

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Months
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 106 N. Greene St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bobby Ray Hatcher

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	—

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug. 24, 1942

8. AGE: Years	Months	Days	If less than one day
3	2	7	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Crockett J. Hatcher
13. Birthplace Tennessee

MOTHER
14. Maiden Name Hazel Grizzle
15. Birthplace Virginia

16 (a) Informant Stanley A. Dyson
(b) Address 106 N. Greene St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-3-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Balto. Md.

18 (a) Funeral director Harry H. Wiltshire
(b) Address 410 E. Monument

NOV 2 1945 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-31- 1945; at 6.20 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fractured 5th Cervical Vertebra
Ruptured Liver
Penetrating of Lung

Other Conditions Multiple fractures, bruised brain and contusions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-31- at 4/2 6.10 P.M.
(b) Where did injury occur? 100 Block N. Greene St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work Employed
(d) Means of injury Playing in the street

23. Signature Thomas J. Mueller M.D.
Medical Examiner.
Date signed 11-1-45

33788 — BALTIMORE CITY HEALTH DEPARTMENT — over — G33788

CERTIFICATE OF DEATH

126 — Registered No.

Write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 days
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town 2773 W. North Ave. (If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore Md (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Albert L. Frankhauser
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex M
5. Color or race W
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Kate Margarethe Bein
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 7-17-1865
8. AGE: Years 80 | Months 3 | Days 13 | If less than one day hr. min.
9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Insurance Broker
11. Industry or business Farmhand

FATHER
12. Name Ernest L. Frankhauser
13. Birthplace Germany

MOTHER
14. Maiden Name Amelie Kletsch
15. Birthplace Germany Frankhausen

16 (a) Informant Albert L. Frankhauser
(b) Address 2773 W. North Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-2-45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Rd

18 (a) Funeral director Harry H. Wilkes
(b) Address 4101 E. Lombard St

19 NOV 2 – 1945 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 30 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-9 1945, to 10-30 1945, and that I last saw h— alive on 10-30 1945.

Immediate cause of death	Duration
Pulmonary Edema	
Due to Post Operative	
Due to Cardiac Strain	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 10-22-45
Major findings of operation: Cholecystitis & Cholelithiasis
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Gray E. Jr M. D.
Address M G Hoop Date signed 10-30-45

VS 180

G33789

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46H

G33789 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2116 W. Fayette St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) V0
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County V
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2116 W. Fayette St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Julia Oliva Alger

3 (b) If veteran, name war None
3 (c) Social Security Account No. None

4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Rubin Alger
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 7, 1879
8. AGE: Years 66 | Months 1 | Days 25 | If less than one day hr. min.
9. Birthplace Middletown Frederick County, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Robert Wilson
13. Birthplace Maryland

MOTHER
14. Maiden Name Unknown
15. Birthplace Maryland

16 (a) Informant Mrs. Stella Sifer
(b) Address 2116 W. Fayette St.

17 (a) Burial (b) Date thereof 11-5-45
(Month) (day) (year)
(c) Cemetery or crematory Pleasant View Cem.
Location [redacted], Frederick County, Md.

18 (a) Funeral director Joseph L. Schwab
(b) Address 2101 Frederick Ave.

19 NOV 2 - 1945 (b) Huntington Williams M.D.
Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 1, 1945 at 5:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/1/45 19__, to 11/1 1945, and that I last saw h__ alive on 11/1 1945.

Immediate cause of death Retroperitoneal sarcoma — Duration 4 mos.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Benjamin Mueller M. D.
Address 2076 Wilkens Ave Date signed 11-2-45

633790

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. 633790

PLEASE WRITE PLAINLY, with UNFADING INK. Every question must be answered. Use additional sheet if necessary. Be sure to state the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1022 Wilmer ct
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1022 Wilmer Ct.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Coleman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race C | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband ~~or wife~~ John Coleman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-17-07

8. AGE: Years 38 | Months 6 | Days 12 | If less than one day hr. min.

9. Birthplace Dallas, Tex.
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name William Robinson
13. Birthplace Annapolis Md.

MOTHER
14. Maiden Name Jennie Chase
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Jennie Chase
(b) Address 1022 Wilmer Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 2, '45 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) 11/2/45 (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-29-1945, at 10P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-21 1945, to 10-29 1945, and that I last saw h~~er~~ alive on 10/25 1945.

Immediate cause of death: Cardio-vascular Renal Disease — Duration: 1 year

Due to: Pulmonary Hemorrhage

Due to:

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.

Address 1004 Carlington Rd. Date signed 10/31

VS 150

G33791

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 132

Registered No. G33791

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 301 S Payson St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) Yo
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 301 S Payson St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME SILVIS MUNKUS (MAUKAS)

3 (b) If veteran, name war: Yes

3 (c) Social Security Account No. 217-03-8377

4. Sex: Male | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1891

8. AGE: Years 54 | Months | Days | If less than one day hr. min.

9. Birthplace RUSSIA (Town, county, and state)

10. Usual Occupation BARTENDER

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant VINCENT GUMASKAS
(b) Address 301 S PAYSON ST

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Nov 3-45 (month) (day) (year)
(c) Cemetery or crematory New Bath. Cem.
Location Frederick Rd

18 (a) Funeral director Joseph Kasmaka Son
(b) Address 607 Washington Blvd

19 (a) 11/2/45 (Date rec'd by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 31 1945, at 9309 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1943, to Oct 29 1945, and that I last saw h[illegible] alive on Oct 29 1945

Immediate cause of death: Coronary Thrombosis — Duration: 8 hours

Due to:

Due to:

Other Conditions: Pulmonary Tuberculosis
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert Hermsen M. D.
Address 1934 Wilkens Av Date signed

94a

6-33792

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G-33792 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Va (b) County
(c) City or town Portsmouth (If outside city or town limits, write RURAL and give town)
(d) Street No. 712 n. Lewis Court (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Herman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary Herman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-4-97.

8. AGE: Years: 48 | Months: 4 | Days: 27 | If less than one day: hr. min.

9. Birthplace St. Mary's Co. Md. (Town, county, and state)

10. Usual Occupation Painter

11. Industry or business

FATHER 12. Name Joseph Herman
13. Birthplace Md.

MOTHER 14. Maiden Name Rose L. ?
15. Birthplace Md.?

16 (a) Informant ——?——
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 5 1945 (month) (day) (year)

(c) Cemetery or crematory
Location Portsmouth, Virginia

18 (a) Funeral director Stewart & Worden Company
(b) Address 108 W. North Av. Balto. Md.

19 11/6/45 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-1-1945 at 9 45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-18 1945 to 11-1 1945, and that I last saw him alive on 11-1 1945.

Immediate cause of death ?Coronary thrombosis — Duration

Due to

Due to

Other Conditions ? regional enteritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John Grant Wilmer M. D.
Address Johns Hopkins Hosp Date signed 11/1/45

VS 180

G33793

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 a

G33793 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entries must be made in this copy and in the copy to be filed with the State Registrar. Do not use abbreviations. Answer each question. If none, write none. If unknown or if the question does not apply, write unknown or the word "does not apply." Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2208 Pelham ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2208 Pelham ave
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Henry G. Horck

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Frances V. Horck
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 26 1879

8. AGE: Years	Months	Days	If less than one day
66	0	4	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Funeral Director
11. Industry or business

FATHER
12. Name Henry J Horck
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Margaret Burns
15. Birthplace Cumberland Md

16 (a) Informant Mrs F. V. Horck wife
(b) Address 2208 Pelham ave

17 (a) Burial (b) Date thereof 11-3-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd
18 (a) Funeral director Kendall E. Humphreys
(b) Address 6067 Harford Rd

NOV 2 1945

(Date received by Registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 30 19 45, at 1 30 PM M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 19 45 to Oct 30 19 45, and that I last saw h alive on Oct 29 19 45.

Immediate cause of death	Duration
Malignant Hypertension Nephritis	30
Due to Cardiac Decompensation	3 yrs
Due to Arteriosclerosis	yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature T B a Stone M. D.
Address 2818 Harford Rd Date signed 11-1-45

X

G33794

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G33794
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fombard & Greene Sts.
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Rural - Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1701 Woodland Dr.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Granville McCartney

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Ora McCartney
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 26, 1876

8. AGE: Years	Months	Days	If less than one day
69	5	5	hr. min.

9. Birthplace West Virginia
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Sylvester McCartney
13. Birthplace West Virginia

MOTHER
14. Maiden Name Julia Moore
15. Birthplace West Virginia

16 (a) Informant Ora McCartney
(b) Address 1701 Woodland Dr.

17 (a) Burial (b) Date thereof Nov. 5, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Meadowridge Mem.
Location Washington Blvd.
18 (a) Funeral director Leonard D. Covington
(b) Address 21 W. 20th St.
19 (a) (Date rec'd by registrar) (Signature) Huntington Williams M.D.

Nov 5 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-31 1945, at 7:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-22 1945 to 10-31 1945 and that I last saw him alive on 10-31 1945.

Immediate cause of death Circulatory Failure — Duration 12 hrs.

Due to Arteriosclerotic Cardio-Vascular Disease — Duration Unknown

Due to

Other Conditions Gangrene of Rt. foot.
(Include pregnancy within 3 months of death)

Date of operation 10-28-45

Major findings of operation: Gangrene of Rt. foot.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Melvin D. Johnson M.D.
Address Univ. Hospital Date signed 10-31-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G33795 ✓ G33795

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Sinai Hospital 76
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 415 S. New Kirk Ave
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Irene Varkipatis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	

6 (b) Name of husband or wife Steve Varripatis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6, 1899

8. AGE: Years	Months	Days	If less than one day
46.	5	21	..... hr. ..... min.

9. Birthplace Greece (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Andrew Biforis
13. Birthplace Greece

MOTHER
14. Maiden Name Stamatoula Sais
15. Birthplace Greece

16 (a) Informant Matina Varripatis
(b) Address 4159 Newkirk

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 3 1945 (month) (day) (year)
(c) Cemetery or crematory Greek Orthodox Cem
Location Baltimore, Md

18 (a) Funeral director Durward L. Covington
(b) Address 241 W. 25th St.

19 NOV 2 - 1945 (Date rec'd by registrar) Covington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/26 1945 at 9:20 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to ..... death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage

Due to Hypertensive C.V. disease

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature P. P. Sakipatis M.D.
Medical Examiner.
Date signed 10/26/45

X

G33796

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52 B

Registered No. G33796

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1812 E. North Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1812 E. North Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM BAUER

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Marion Dale Elliott
6 (c) If alive, give age 87 years

7. Birth date of deceased (mo., day, yr.) Oct 3, 1858

8. AGE: Years	Months	Days	If less than one day
87	0	28	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Engineer, Penne. R.R.
11. Industry or business Retired 1923

FATHER
12. Name John Bauer
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Hess
15. Birthplace Germany

16 (a) Informant Mrs. Marion Bauer
(b) Address 1812 E. North Avenue

17 (a) Burial (b) Date thereof 11-3-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) Date received by Registrar (b) [illegible]
NOV 2 1945 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION A.M.

20. DATE OF DEATH October 31 1945, at 7.15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 12th. 1945 to Oct. 31st. 1945.
and that I last saw h im alive on Oct. 30th 1945.

Immediate cause of death	Duration
Myocardial Insufficiency	about 2 yrs.
Due to Arteriosclerosis	unknown
Due to ----------	
Other Conditions Carcinoma of Bladder	about 2yrs

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jas. W. Montgomery M.D.
Address 401 E. 25th. St. Date signed 11/1/45. M. D.

PLEASE WRITE CLEARLY, with pen and ink, and use only capital letters. Be sure to write the causes of death clearly and legibly. Correct age is especially important. Physicians: please write your address plainly.

G33797

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

CWK-96910

13B

Registered No. G33797

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 49- 3- 1-

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4005 Ridgecroft Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helen Born

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 30-1896

8. AGE: Years	Months	Days	If less than one day
49	3	1	hr. min.

9. Birthplace Maryland.
(Town, county, and state)

10. Usual Occupation Saleslady

11. Industry or business May Co.

FATHER
12. Name Henry Born
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Miller
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof 11-5-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto, Md.

18 (a) Funeral director Leonard J. Rusk
(b) 4 Hartford Rd.

19 (a) NOV 2 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 1 1945, at 6:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 26 1945, to Nov. 1 1945, and that I last saw h[illegible] alive on Nov. 1 1945

Immediate cause of death	Duration
Pulmonary Tuberculosis	2
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert B. Copeland Jr.
Address Balto City Hosp. Date signed 11/1/45

M.D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

33798

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1600

✓ G33798 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hosp. 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 6 days.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1411 Lemon St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/20/45

8. AGE: Years	Months	Days	If less than one day
		6	hr. min.

9. Birthplace University Hospital Balt. Md. (city, county, and state)

10. Usual Occupation

11. Industry or business Infant.

FATHER
12. Name Frank Johnson
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Florence E. Rogers
15. Birthplace Baltimore Md.

16 (a) Informant Birth Certificate
(b) Address # G-33294

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location University Medical School OCT 9 1945

18 (a) Funeral director Commissioner of Health.
(b) Address

NOV 2 1945 (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/26 1945, at 7:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/20 1945 to 9/26 1945 and that I last saw h[illegible] alive on 9/26 1945.

Immediate cause of death Intracranial Hemorrhage — Duration

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. Robert Mark M. D.
Address Univ. Hosp. Date signed 9/26/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every question must be answered. If unknown or if not applicable, write word "unknown" or "none." Information should be entered for every item, and the correct age is especially important. Physicians: please write the cause of death clearly and legibly.

VS 150

3003 1/2 X

G33799 BALTIMORE CITY HEALTH DEPARTMENT G33799
CERTIFICATE OF DEATH 93D Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1013 E. Biddle St
(c) Hospital or institution:
at Home 10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1013 E. Biddle St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John J. Callahan

3 (b) If veteran, name war: No
3 (c) Social Security Account No.:

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 5, 1900

8. AGE: Years 45 | Months 0 | Days 25 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Patrolman on Beat

11. Industry or business City Service

FATHER
12. Name John J. Callahan
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary A. McCormick
15. Birthplace Ireland

16 (a) Informant Mrs. Mary R. Beamundo
(b) Address 3209 Ensor Green Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 3, 1945 (month) (day) (year)
(c) Cemetery or crematory Mount Cathedral Cemetery
Location 4300 Old Frederick Rd.

18 (a) Funeral director Elmer W. Conklin & Son
(b) Address 924 E. Fayette St Baltimore, Md.

NOV 2 – 1945 (Date rec'd by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 30, 1945 at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 19 , to Oct 29 1945.
and that I last saw h[illegible] alive on Oct 29 1945.

Immediate cause of death: Acute cardiac failure — Duration
Due to: Chr Hypertension
Due to: Acute Nephritis
Other Conditions: Chr myocarditis.
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. L. Hornstein
Address 733 Augusta St. Date signed 10/31/45 M D.

VS 3

130

G33800

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G33800 Registered No.

131a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Frederick
(c) City or town ~~Baltimore~~ Libertytown
(If outside city or town limits, write RURAL and give town)
(d) Street No. Union Bridge, Route 2
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Harriet Dorsey Jones

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 28, 1877

8. AGE: Years: 68 | Months: 5 | Days: 3 | If less than one day: hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name J. Dorsey Jones
13. Birthplace Maryland

MOTHER
14. Maiden Name Cornelia Hammond
15. Birthplace Maryland

16 (a) Informant J. Dorsey Jones
(b) Address Libertytown, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/2/45 (month) (day) (year)
(c) Cemetery or crematory FAIRMOUNT
Location Libertytown, Md.

18 (a) Funeral director Harry E. Coats Co.
(b) Address Frederick, Md.

19 (a) Nov. 1 1945 (Date rec'd by registrar) Huntington Williams Registrar

V 2-1945

MEDICAL CERTIFICATION

20. DATE OF DEATH October 31 1945 at 3:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 23 1945 to Oct 31 1945 and that I last saw her alive on Oct 31 1945

Immediate cause of death Uremia — Duration ?

Due to Nephrosclerosis

Due to Arteriosclerotic Heart Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Crawford N. Kilpatrick, Jr. M. D.
Address Union Memorial Hosp. Date signed 10-31-45

X

G33801

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 119a

Registered No. G33801

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Edmondson & Gwynn
(c) Hospital or institution:
University Hospital 19
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balt. Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1715 N. Saratoga St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jinna Mason

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/19/45

8. AGE: Years	Months	Days	If less than one day
	4	5	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Charles Loyd Thomas
13. Birthplace Laurel Md.

MOTHER
14. Maiden Name Mary Eliza Mason
15. Birthplace Winston Salem N.C.

16 (a) Informant Birth Certificate
(b) Address #E-24696

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School OCT 9 1945

18 (a) Funeral director Commissioner of Health
(b) Address

NOV 2 1945 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/24 1945, at 4:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/21 1945 to 9/24 1945, and that I last saw h[illegible] alive on 9/24 1945.

Immediate cause of death Cardiac & dehydration — Duration
Due to diarrhoea
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A Robertson M.D.
Address Univ Hosp Date signed 9/24/45

Please write plainly, using ink. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

3004 1/2

G33802

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G33803 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4013 Liberty Heights Ave.
(c) Hospital or institution:
Wells Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Rockdale
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5616 Marriott Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry I. Marriott

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 4, 1881

8. AGE: Years	Months	Days	If less than one day
64	7	27	hr. min.

9. Birthplace Baltimore County, Md.
(Town, county, and state)
10. Usual Occupation Roofer
11. Industry or business

FATHER
12. Name James A. Marriott
13. Birthplace Baltimore County, Md.

MOTHER
14. Maiden Name Ida V. Sauma
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. J. A. Marriott, Jr.
(b) Address 5614 Marriott Lane, Rockdale

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 3, 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Olive Cemetery
Location Randallstown, Md.

18 (a) Funeral director E. Willis Lamsman
(b) Address 4510 Liberty Heights Ave.

19 (a) 1945 (Date) (b) Registrar Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH November 1 1945, at 2 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 2 1945, to Oct. 31 1945, and that I last saw h. in alive on Oct. 31 1945.

Immediate cause of death	Duration
Cerebral Hemorrhage	1 week
Due to Carcinoma of Sigmoid & Rectum	
Due to Pulmonary Embolism	3 days
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. C. Smith M. D.
Address 4509 Liberty Heights Ave. Date signed

VS 180

G33803

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G33803

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 617 N. East Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26-10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 617 N. East Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nellie Grant Holmes

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Charles Holmes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 8, 1878

8. AGE: Years	Months	Days	If less than one day
67	-	23	hr. min.

9. Birthplace Trappe, Calvert County, Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name William Mullikin
13. Birthplace unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Charles Franklin Holmes
(b) Address 617 N. East Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-3-45 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location North Avenue and Rose Street

18 (a) Funeral director Frederick D. Miller, Inc
(b) Address 3019 E. Monument Street

19 (a) NOV 3 1945 (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 1st 19 45, at 4.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 19 44 to Nov 1 1945
and that I last saw h 9 alive on Nov 1 1945.

Immediate cause of death Arteriosclerosis,

Due to Hypertension - Cardio Vascular Renal Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
2 yrs.
1 yr.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James F. Karzenski M.D.
Address 3328 McElderry St. Date signed N-2-45
M. D.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Be careful to write correct age in words and figures. Information should be carefully supplied; please write the causes of death clearly and legibly. Physicians: please correct age is especially important.

G33804

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 F

G33804 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3205 Berkshire Rd.
(c) Hospital or institution:

27-1

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3205 Berkshire (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harriet Jane Slothower

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Alfred H.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Sept. 23 1856

8. AGE: Years 89 | Months 1 | Days 9 | If less than one day ... hr. ... min.

9. Birthplace: Sondersburg Pa.
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Michael Sonders
13. Birthplace: Sondersburg Pa.

MOTHER
14. Maiden Name: Eliza Ann Holson
15. Birthplace: Sondersburg Pa.

16 (a) Informant: Mrs. Mildred H. Spangler
(b) Address: 3205 Berkshire Rd.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11/2/45 (month) (day) (year)
(c) Cemetery or crematory: Phila Pa.
Location:

18 (a) Funeral director: Wm. J. Tickner & Sons
(b) Address: North & Pa. Aves.

NOV 3 - 1945 (Date rec'd by registrar) Huntington Mills

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 2, 1945, at 11:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 4 1943, to Nov. 2 1945, and that I last saw him alive on Nov. 1 1945.

Immediate cause of death	Duration
Chronic Myocarditis	15 yrs
Due to Myocardial degeneration	
Due to Arteriosclerotic-renal disease	
Other Conditions Carcinoma liver	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. V. Harbold

Address 4706 Harford Road Date signed 11/2/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Examine the information entered on the certificate after the undertaker supplies it. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

633805

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1248 633805

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Redwood & Greene
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days): 34 days
(e) Length of stay in Baltimore (yrs., mos., or days): 34 day

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County: Harford
(c) City or town: Havre de Grace
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 316 N. Union Ave
(If rural give location)
(e) Citizen of foreign country?: (Yes or No)
If yes, name country:

3 (a) FULL NAME William M. Nicol

3 (b) If veteran, name war: —

3 (c) Social Security Account No.: -

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife: Thelma

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept 2, 1913

8. AGE: Years	Months	Days	If less than one day
32	2	9	0 hr. min.

9. Birthplace: Scotland
(Town, county, and state)

10. Usual Occupation: Chiropractor

11. Industry or business:

FATHER — 12. Name: Mather

13. Birthplace: Harvie de Scotland

MOTHER — 14. Maiden Name: Martha Mackie

15. Birthplace: Scotland

16 (a) Informant: C. M. Stewart

(b) Address: Aberdeen, Papua

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 11/3/45 (month) (day) (year)

(c) Cemetery or crematory: St Louis Cath Aberdeen

Location: Aberdeen, Md.

18 (a) Funeral director: Wilson Cookson

(b) Address: 1214 E. Fort Ave

19 (a) (Date rec'd by registrar): Huntington Williams, Mgr

NOV. 3. - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-2 1945, at 11:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-6 1945 to 11-2 1945 and that I last saw h[illegible] alive on 11-2 1945

Immediate cause of death: Cirrhosis of Liver — Duration

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation: 10-22-45

Major findings of operation: Exploratory Laparotomy

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: W. Dorcas Clark M. D.

Address: University Hosp. Date signed: 11-2-45

633806

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

633806

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5711 Seymour Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26-1

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4319 Bayonne Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Arabella Virginia Reese Erdman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Fe	Wh	W

6 (b) Name of husband or wife Wilbur H. Erdman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 6, 1863

8. AGE: Years	Months	Days	If less than one day
82	7 8	27	hr. min.

9. Birthplace Lewistown, Maryland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At home

FATHER
12. Name John Reese
13. Birthplace Talbot County, Md.

MOTHER
14. Maiden Name Rhoda Sullivan
15. Birthplace Talbot Co., Md.

16 (a) Informant Mrs. Daughaday
(b) Address 5713 Seymour Ave.

17 (a) Burial (b) Date thereof 11-5-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem
Location Balto-Md

18 (a) Funeral director Langahn Funeral Home
(b) Address 7401 Belair Rd

19 (a) (b)
Filed by Registrar NOV 3 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 2 1945, at 5.50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 18 1945, to Nov 2 1945, and that I last saw her alive on Nov 2 1945.

Immediate cause of death	Duration
Cerebral hemmorrhage	16 days
Due to Arterio-sclerosis	Many yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. L. Wilkinson
A. L. Wilkinson, M.D.
Address 5713 Bel Air Rd. Date signed 11/3-45

X

633807

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

633807 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every question must be answered. Use figures for dates. Be sure to state the causes of death clearly and legibly. Be sure that information about the deceased is correct and complete. Be sure that the age is correct. Be sure that the cause of death is correct. Be sure that the date of death is correct. Be sure that the place of death is correct. Be sure that the name of the deceased is correct. Be sure that the age is especially important. Physicians: please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 82 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7001 Beach Ave.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Jefferson Davis Hayes

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W	M.

6 (b) Name of husband or wife Mary Christine Hayes
6 (c) If alive, give age 77 years

7. Birth date of deceased (mo., day, yr.) May 24, 1863

8. AGE: Years	Months	Days	If less than one day
82	5	8	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Mill owner
11. Industry or business Hay, grain & feed Brokerage

FATHER 12. Name	John Hayes.
13. Birthplace	England
MOTHER 14. Maiden Name	Annie Elizabeth Baker
15. Birthplace	England

16 (a) Informant ~~Frances Elizabeth Baker~~ Samuel L. Hayes
(b) Address 7001 Beach Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 5 45 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto Md.

18 (a) Funeral director Langhorne Funeral Home
(b) Address 7401 Belair Rd.

19 (a) (Date rec'd by Registrar) (b) Livingston Williams, M.D. Registrar NOV 3 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/1 1945, at 7:17 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/18 1945 to 11/1 1945 and that I last saw him alive on 11/1 1945.

Immediate cause of death Cardiac — Respiratory failure.
Due to Degenerative Cardio Vascular disease
Due to Seminoma Cancer of descending Colon.
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 10/30/45.
Major findings of operation: Unresectable Cancer descending Colon.
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. L. Brindle M. D.
Address Mercy Hosp. Date signed 11/1/45

VS 150

G33808

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G33808 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1753 E NORTH AVE
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-5
(e) Length of stay in Baltimore (yrs., mos., or days) 82

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO CITY.
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1753 E. NORTH AVE
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE CLIFTON WILMER

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	WIDOWER

6 (b) Name of husband or wife SARAH LOUISE
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 16 1863

8. AGE: Years	Months	Days	If less than one day
82	2	15	hr. min.

9. Birthplace BALTIMORE
(Town, county, and state)
10. Usual Occupation MECHANIC
11. Industry or business

FATHER
12. Name PERE WILMER
13. Birthplace CENTERVILLE MD.

MOTHER
14. Maiden Name MARY ELLEN MASON
15. Birthplace ✓

16 (a) Informant MRS JOSEPHINE WILLIAMS
(b) Address 1753 E NORTH AVE

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/5/45
(month) (day) (year)
(c) Cemetery or crematory WESTERN Cemetery
Location EDMONDSON AVE

18 (a) Funeral director HOWARD N BLIGHT, JR
(b) Address 4914 BELAIR RD

19 NOV 3 - 1945 (b) Huntington Williams, M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct-31- 1945, at 12-30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1- 1945 to Oct 31 1945 and that I last saw h.. alive on Oct 31- 1945.

Immediate cause of death — Duration

Coronary Thrombosis — 1 day.
Due to Arteria Sclerosis — 10 yrs
Due to
Other Conditions
(Include pregnancy within 3 months of death).
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. Gill Hall M. D.
Address 1631 E. North Ave. Date signed 11/1/45

VS 150

X

FILL OUT WITH PENCIL, WITH ONE ENTRY IN A SPACE. Every item of information should be carefully considered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G33809

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH √48a

G33809 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entries must be made in permanent black ink or typewriter. Use no abbreviations. If unknown, write "unknown." If not applicable, write "none." Do not use ditto marks. Be sure and write the cause of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 days
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Stevenson Town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1008 L Street (Eye St)
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ravena Davis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Robert Davis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-13-'07

8. AGE: Years 38 | Months 10 | Days 18 | If less than one day hr. min.

9. Birthplace Prince Edward Co., Va.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name William Green

13. Birthplace Va

MOTHER 14. Maiden Name Mary Woodson

15. Birthplace Va

16 (a) Informant Robert Davis

(b) Address 1008 L St. Stevenson Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-5-45 (month) (day) (year)

(c) Cemetery or crematory

Location Prospect Va

18 (a) Funeral director Samuel M. Neal & Son

(b) Address 638 N. Gilmor St

19 (a) (Signature of local registrar) (b) Huntington Williams, M.D. Registrar

NOV 9 - 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 1 1945, at 3.50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-11 1945, to 11-1 1945, and that I last saw her alive on 11-1 1945.

Immediate cause of death Metastatic carcinoma of Lungs — Duration 2-4 months (Estimate)

Due to Adeno-Carcinoma of Cervix uteri

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.

Address [illegible] Date signed 11/2/45

G33810
JL - 53368

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1313

G33810
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 - 7 - 28
(e) Length of stay in Baltimore (yrs., mos., or days) 29 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 903 Shields Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Hall

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March10,1892

8. AGE: Years	Months	Days	If less than one day
53	7	19	hr. min.

9. Birthplace N. C.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name William
13. Birthplace N. C.

MOTHER
14. Maiden Name Rose Dergelo
15. Birthplace N. C.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 11-3-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

19 (a) (b) Huntington Williamsport, Md.
(Date of registry)
NOV 3 - 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 29 1945, at 7p M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1 1945 to Oct. 29 1945, and that I last saw him alive on Oct. 29 1945

Immediate cause of death	Duration
Pulmonary Tuberculosis	7
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy No post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert B. Cleland Jr M. D.
Address Balto. City Hosp. Date signed 10/30/45

X

Please write clearly, with ink. Fill in all blanks. Be sure the causes of death clearly and legibly. correct age is especially important. Physicians: please write the

G33811

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 96

G33811

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rehabilitation Program
(c) Hospital or institution: West Baltimore General Hospital 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Mt Washington (If outside city or town limits, write RURAL and give town)
(d) Street No. 6101 Maywood Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward O. Penniman

3 (b) If veteran, name war ✓
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married.
6 (b) Name of husband or wife: Helen R. Penniman
6 (c) If alive, give age years: Wife
7. Birth date of deceased (mo., day, yr.) 2-18-81
8. AGE: Years 64 Months 7 Days 10 If less than one day hr. min.
9. Birthplace Balto. (town, county, and state)
10. Usual Occupation Engineer
11. Industry or business Carrollton Bank
FATHER 12. Name Edward J. Penniman
13. Birthplace Balto
MOTHER 14. Maiden Name Naomi Worrell
15. Birthplace Balto.
16 (a) Informant Helen R. Penniman
(b) Address 6101 Maywood Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 3 '45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.
18 (a) Funeral director John A. McShain Inc
(b) Address 1401 Eutaw Place
19 (a) (Date rec'd by registrar) (b) Registrar
NOV 3 - 1945 Huntington Avenue

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/1 1945, at 10:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/31 1945, to 11/1 1945, and that I last saw h[illegible] alive on 11/1 1945

Immediate cause of death	Duration
Ruptured Aortic Aneurysm	
Abdominal Aortitis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Ruptured Aneurysm

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M.D.
Address Md. Wd. Baltimore General Hospital Date signed 11/1/45

VS 150

X

633812

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd Street
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1215 Bolton Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. John Charles Lewis

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Mrs. John C. Lewis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 26, 1871

8. AGE: Years	Months	Days	If less than one day
73	11	6	hr. min.

9. Birthplace Washington, D.C. (City or county, state or foreign country)
10. Usual Occupation Wife of Lt. Comm. Bill Lewis
11. Industry or business

FATHER
12. Name William I. Lewis (D)
13. Birthplace Connecticut

MOTHER
14. Maiden Name Isadore J. Winship (D)
15. Birthplace Virginia

16 (a) Informant Helen R. Lewis
(b) Address 1216 Bolton St.

17 (a) Cremation (b) Date thereof Nov 5/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto. Co. Md.

18 (a) Funeral director John Ehrenfeld
(b) Address 1960 Eastern Place

19 (a) NOV 3 - 1945 Registrar
(Date rec'd by registrar)

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 2 1945, at 9:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/28/1945 to 11/2/1945, and that I last saw him alive on 10/2 1945

Immediate cause of death	Duration
Cardiac insufficiency, failure	
Due to arteriosclerotic heart disease	
Due to	
Other Conditions Benign prostatic hypertrophy	
(Include pregnancy within 3 months of death)	
Date of operation 0	
Major findings of operation: 0	
of autopsy: 0	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Crawford N. Kirkpatrick, Jr. M.D.
Address Union Memorial Hosp. Date signed 11-2-45

Huntington for Williams, M.D.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

G33813

TN. G33813 96754

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 E

Registered No. G33813

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days
(e) Length of stay in Baltimore (yrs., mos., or days) 79 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 826 Mt. Holly Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country Germany

3 (a) FULL NAME Ernest Seifert

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 22, 1865

8. AGE: Years 80 | Months 1 | Days 9 | If less than one day hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Edward Seifert
13. Birthplace Germany

MOTHER
14. Maiden Name Ernestine Huffman
15. Birthplace Germany

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/3/45 (month) (day) (year)
(c) Cemetery or crematory Loan Tree
Location Pulaski Highway

18 (a) Funeral director J. J. Foley Sons
(b) Address 1 E. Lafayette St.

19 (a) Received here NOV 3 1945 (b) Interred, removed, or cremated at Baltimore, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 31 1945 19 at 11.30 P.M. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 18th 19 45 to Oct 31 19 45 and that I last saw h im alive on Oct 31 1945

Immediate cause of death Cardiac Arrest — Duration

Due to Cachexia

Due to Generalized Carcinoma

Other Conditions Angina infect obstruction

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Eugene A. Patterson
Address Balto City Hosp Date signed 11-1-45
M. D.

G33814

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

G33814
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) 12 days

2. USUAL RESIDENCE OF DECEASED:
(a) State ~~Md~~ Pa (b) County Franklin
(c) City or town Mont Alton
(If outside city or town limits, write RURAL and give town)
(d) Street No. —
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (Mrs) Lillie Bumbaugh

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Oscar

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1868

8. AGE: Years 57 | Months — | Days — | If less than one day ... hr. ... min.

9. Birthplace Pa (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business —

FATHER
12. Name Jacob Reed
13. Birthplace Pa

MOTHER
14. Maiden Name Annie Shaffer
15. Birthplace Md

16 (a) Informant Oscar Bumbaugh
(b) Address Mt Alto, Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 6-45 (month) (day) (year)

(c) Cemetery or crematory Quincy Cem.
Location Quincy, Pa.

18 (a) Funeral director Fred W. Kaufman
(b) Address Hagerstown, Md.

19 (a) NOV 3 - 1945 (Registrar) Huntington Wilson, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-2 1945 at 5:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-21 1945 to 11-2 1945, and that I last saw her alive on 11-2 1945.

Immediate cause of death Respiratory failure — Duration

Due to Carcinoma of Lt breast — Also complete renal failure.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Radical Mastectomy & axillary dissection 10-22-45

Major findings of operation: Carcinoma

of autopsy: not done.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. Dorcas Clark M. D.
Address Redwood & Greene Date signed 11-2-45

VS 150

G33815

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92a

Registered No. G33815

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 706 Bruns St
(c) Hospital or institution:
17
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 706 Bruns St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martha Ward

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	colored	widowed

6 (b) Name of husband or wife Elias Ward
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 13, 1884

8. AGE: Years	Months	Days	If less than one day
60	11	19	hr. min.

9. Birthplace Wash. D. C.
(Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Mary Ward
(b) Address 706 Bruns St

17 (a) Burial (b) Date thereof 11-5-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St Peters Cem.
Location md

18 (a) Funeral director George S. Kelson
(b) Address 1303 Pennsylvania Ave

19 (a) (b)
(Division) (Registrar)

NOV 8 - 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 2 1945 at 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-4 1945 to 11-7 1945 and that I last saw him alive on 11-1-1945

Immediate cause of death	Duration
Acute Regurgitat. Dis.	
C Cardiac Hypertrophy	11
Due to	
Due to —	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. N. Hatcher M. D.
Huntington Williams, Md. 1775 Pa Ave Date signed 11/7/45

G33816

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 B2

Registered No. G33816

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given. Do not omit the causes of death clearly and legibly. Physicians: please write the correct age is especially important. Supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline Hoffmanns
(c) Hospital or institution:
St. Joseph's Hosp. 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1226 N. Stricker St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Elsie ANDERSON (Fields)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6 | 22 | 05

8. AGE: Years	Months	Days	If less than one day
40	4	11 10	hr. min.

9. Birthplace Washington
(Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name Branch Grinnell
13. Birthplace Virginia

MOTHER
14. Maiden Name Maria (unknown)
15. Birthplace Virginia

16 (a) Informant sister
(b) Address 1226 N. Stricker St

17 (a) Burial (b) Date thereof 11-5-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arlington
Location Forest

18 (a) Funeral director George E. Kelly
(b) Address 1303 Pennsylvania Ave

19 (a) NOV 3 1945 Registrar
(Date received by registrar)

Huntington Hillsman, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 2, 1945, at 4:01 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 28 1945, to Nov. 2 1945; and that I last saw her alive on Nov. 2 1945.

Immediate cause of death	Duration
Perforation of Stomach	
of peritonitis	
Due to Carcinoma	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert Jamouth M.D.

Address St. Joseph Hospital Date signed 11/3/45

X

633817

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

633817 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1100 Sargent Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1100 Sargent Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME AMANDA BUHL

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife William L. Buhl
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 30, 1868

8. AGE: Years	Months	Days	If less than one day
77	3	1	hr. min.

9. Birthplace Caroline Co., Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Peter Hubbert
13. Birthplace Md.

MOTHER
14. Maiden Name Not known
15. Birthplace Md.

16 (a) Informant Mr. Herbert O. Buhl, son
(b) Address 2245 Penrose Ave.

17 (a) Burial (b) Date thereof 11/5/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address Balto., Md.

19 (a) (b) Registrar
(Date received by Local Registrar)

NOV 3 1945

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 1, 1945 at 10:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1940 to Nov. 1st 1945, and that I last saw h[illegible] alive on Oct 29 1945.

Immediate cause of death Edema of lungs.

Due to Myocardial insufficiency

Due to Chronic hypertension cardiovascular disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
s
1 yr.
Years Months Days Hours

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter E. Stampler M. D.
Address 1018 Poplar Grove St Date signed Nov. 2 1945

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Type-writing is preferred. Be sure to state the causes of death clearly and legibly. The correct age is especially important. Physicians: please write this

G33818

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121

Registered No. G33818

PLEASE WRITE PLAINLY, WITH INK. PRINTING INCREASES THE COST OF RECORDING. Every question must be answered. Physicians: please write the correct age in years, months, days, hours, or minutes. Give the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West. Balt. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2806 Walbrook Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME May Mattie Unkle

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	Widow

6 (b) Name of husband or wife Clarence Unkle
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 20, 1890

8. AGE: Years	Months	Days	If less than one day
55	2	12	hr. min.

9. Birthplace Balt., Md. (Town, county, and state)
10. Usual Occupation Executive
11. Industry or business Jamgotch Co.

FATHER
12. Name James A. Dyott
13. Birthplace Md.

MOTHER
14. Maiden Name Martha W. Fairbank
15. Birthplace St. Michaels, Md.

16 (a) Informant Mr. Herbert B. Dyott
(b) Address 3815 Clifton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/6/45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

NOV 3 - 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 2, 1945 at 1:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 28 1945 to Nov-2 1945 and that I last saw h e alive on Nov - 2 1945

Immediate cause of death Peritonitis, Generalized — Duration 10 days

Due to Ruptured appendix

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Nov 2 - 1945 - 12:30 P M

Major findings of operation: Generalized peritonitis with Ruptured Appendix

of autopsy: yes —

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Floyd D. Taylor M. D.
Address West Balt Gen Hosp Date signed Nov 2, 45

633819

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. 633819

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Pikesville (If outside city or town limits, write RURAL and give town)
(d) Street No. 7102 Plymouth Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mr. Wilbur W. Shaw

3 (b) If veteran, name war: None
3 (c) Social Security Account No. 216-24-1665

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife: Elizabeth A. Shaw
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Jan. 11, 1890

8. AGE: Years: 55 | Months: 9 | Days: 20 | If less than one day: hr min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Advertising
11. Industry or business: Self

FATHER
12. Name: George W. Shaw
13. Birthplace: Balto., Md.

MOTHER
14. Maiden Name: Annie Hall
15. Birthplace: ?

16 (a) Informant: Mrs. Elizabeth A. Shaw
(b) Address: 7102 Plymouth Rd. 8

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/5/45 (month) (day) (year)
(c) Cemetery or crematory: Woodlawn Cem.
Location: Woodlawn, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 NOV 3 - 1945 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 | 1 | 1945, at 9:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10 | 30 | 1945 to 11 | 1 | 1945 and that I last saw him alive on 11 | 1 | 1945

Immediate cause of death: Cerebral Hemorrhage — Duration: 24 hrs.
Due to: Hypertensive C.V. Disease
Due to:
Other Conditions: 2nd Anemia; Post. Op. Hemorrhoidectomy
(Include pregnancy within 3 months of death)
Date of operation 10/31/45
Major findings of operation: Thrombotic Hemorrhoids
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Chas. Martin, Jr. M.D.
Address Bon Secours Hosp. Date signed 11/1/45

Fill in with typewriter, pen, or pencil. Physicians: please write the correct age is especially important.

G338c0
JL 90758

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1838

Registered No. G338c0

Please write the causes of death clearly and legibly. Physicians: please write the cause of death clearly and legibly. Please write age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 13-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 11
(e) Length of stay in Baltimore (yrs., mos., or days) 28 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2203 Lynbrook St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William H. Ford

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Minnie Ford
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 2, 1877

8. AGE: Years	Months	Days	If less than one day
67	11	29	hr. min.

9. Birthplace Washington, D. C. (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business

FATHER
12. Name ? Charles S. Ford
13. Birthplace ? Washington, D. C.

MOTHER
14. Maiden Name ? Mary Crockett
15. Birthplace ? Boston, Mass.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/3/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 3 1945 (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 31 1945, at 7.45P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 20 1944 to Oct. 31 1945 and that I last saw him alive on Oct. 31 1945

Immediate cause of death: Bronchopneumonia — Duration: 3 days
Due to
Due to
Other Conditions: Repaired contd. Uremia — Duration: 1 yr.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Empir

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. Woodward M.D. M. D.
Address Baltimore City Hospitals Date signed 11-1-45

107

G33821

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G33821 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given. Write the causes of death clearly and legibly. correct age is especially important. Physicians: please write

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2803 Garrison Blvd.
(c) Hospital or institution:
Garrison Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1907 Cedrick Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HELEN H. GUDE

3 (b) If veteran, name war	3 (c) Social Security Account No.
nohe	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 24, 1863

8. AGE: Years	Months	Days	If less than one day
82	4	7	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Henry P. Gude
13. Birthplace Germany

MOTHER
14. Maiden Name Johanne F. --
15. Birthplace Germany

16 (a) Informant Mr. William C. Fraser
(b) Address 2624 St. Paul St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/3/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Nov 3 1945 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 1, 1945, at 11 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-25 1945, to 11-1-1945, and that I last saw her alive on 11-1 1945.

Immediate cause of death	Duration
Acute Congestion Cardiac Failure	3 days.
Due to Arteriosclerosis.	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Howard F. Warner M. D.
Address 2614 Garrison Blvd. Date signed 11-1-45

VS 150

X

G33822

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G33822 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline & Hoffman
(c) Hospital or institution:
St. Joseph's Hospital 2

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 12
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5600 York Rd. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Peter Albert Jordan

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	SINGLE

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 10/31/45

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation newborn infant
11. Industry or business

FATHER
12. Name Frank Barclay Jordan
13. Birthplace Kansas City, Mo.

MOTHER
14. Maiden Name Katherine Suzanne Binsfield
15. Birthplace Kansas City, Mo.

16 (a) Informant Mrs. F B. Jordan
(b) Address 5600 York Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/3/45 (month) (day) (year)
(c) Cemetery or crematory St Mary's
Location Baltimore Md
18 (a) Funeral director Wilhelm Son & Lee
(b) Address 2317 N. Charles St

NOV 3 - 1945 (b)
(Date rec'd by registrar) Registrar
Huntington Hillegeas, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 2 1945; at 11:57 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 31 1945 to Nov. 2 1945, and that I last saw h.i.M. alive on Nov. 2 1945.

Immediate cause of death	Duration
Pneumonia	
Due to Prematurity & Atelectasis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Helen Jamarski
Address St Joseph's Hospt. Date signed 11/2/45 M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G33823

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G33823 Registered No.

Write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 22-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dom
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 649 Haw St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Henriette Spriggs

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: W

6 (b) Name of husband or wife: —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 10, 1891

8. AGE: Years 54 | Months 1 | Days 22 | If less than one day hr. min.

9. Birthplace Balt. Co. Md. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Alfred Scott
13. Birthplace Md.

MOTHER
14. Maiden Name Susie Scott
15. Birthplace Md.

16 (a) Informant Hilda Bonds
(b) Address 548 W. Conway St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/5/45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brentalley Ave

19 NOV 3 1945 (b) Huntington Ave. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 2nd 1945, at 3:55 P. M

21. I certify that I took charge of the remains described above, held an Autopsy / Inspection on Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mueller M.D. Medical Examiner.
Date signed 11-2-45

G33824 -

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

110 B

Registered No. G33824

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14- 8 -23
(e) Length of stay in Baltimore (yrs., mos., or days) 54 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 15 N. Poppleton St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Grace Hodges

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? 1875

8. AGE: Years	Months	Days	If less than one day
70 ?	?	?	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Cook

11. Industry or business

FATHER
12. Name Charles ?
13. Birthplace Md.

MOTHER
14. Maiden Name Annie ?
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 3, 45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cem
Location Baltimore Md

18 (a) Funeral director Isaiah R Brannon Son
(b) Address 1058 Montgomery Street

NOV 3 1945 Registered by [illegible] Huntington Williamsport

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 30 1945, at 4.05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 7, 1931 to Oct. 30 1945, and that I last saw her alive on Oct. 30 1945

Immediate cause of death Bronchopneumonia — Duration 3 days

Due to [illegible]

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Intermuscular Hydrothorax

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Margaret Downs M. D.
Address 4940 Eastern Ave. Date signed 11-2-45

VS 150

PLEASE WRITE PLAINLY, with unfading ink. Fill in all blanks. Be sure to state the causes of death clearly and legibly. Be sure correct age is especially important. Physicians: please write the

G338825

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G338825 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3628 Old York Road
(c) Hospital or institution:
at Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3628 Old York Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret M. Steinfeldt

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: J. Albert Steinfeldt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 26 1863

8. AGE: Years 82 | Months 6 | Days 5 | If less than one day hr. min.

9. Birthplace Baltimore Co., Md. (Town, county, and state)

10. Usual Occupation Home work

11. Industry or business at Home

FATHER
12. Name Conrad Schuppert
13. Birthplace Germany

MOTHER
14. Maiden Name Sophia Bush
15. Birthplace Germany

16 (a) Informant Mrs. Mary Gibson
(b) Address 3628 Old York Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 5, 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Cathedral Cem.
Location 4300 Old Frederick Rd

18 (a) Funeral director Elmer W. Conklin's Son
(b) Address 924 E. Eager St.

19 NOV 3 - 1945 (b) Registrar
(Date rec'd by registrar)

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 31, 1945, at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-2-1940 to 10-31-1945 and that I last saw her alive on 10-31-1945

Immediate cause of death	Duration
Arteriosclerotic cardio renal disease	Unknown
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. B. Seybert M. D.
Address 102 Harford Rd Date signed 11-2-45

Huntington Nurseries, Inc.

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

Dr. Louis Krumrein
722 N. Kenwood Ave.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. 6338:26

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item or information should be carefully supplied. Be sure the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 920 E. Preston St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 920 E. Preston St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bernice Elizabeth Dressell

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife Russell F. Dressell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 13, 1888

8. AGE: Years	Months	Days	If less than one day
57	9	19	hr. min.

9. Birthplace Petersburg, Virginia
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name ? Newcomb
13. Birthplace Va.

MOTHER
14. Maiden Name Josephine L. Newcomb
15. Birthplace Va.

16 (a) Informant Mr. Russell F. Dressell
(b) Address 920 E. Preston Street

17 (a) Burial (b) Date thereof 11/5/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory WOODLAWN
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 NOV 3 - 1945 Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 1st., 1945 at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 27 1945 to Nov 1 1945 and that I last saw [illegible] alive on Oct 31 1945

Immediate cause of death Coronary Thrombosis — Duration 10 d/45

Due to Arteriosclerosis & Hypertension. — July 27/45

Due to

Other Conditions Diabetes Mellitus —

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury —

23. Signature Louis F. Krumrein M. D.
Address 722 N. Kenwood Ave Date signed Nov 3/45

VS 150

8313

G33827
482467

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

157E

Registered No. G33827

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution:
JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State N.Y. (b) County.....
(c) City or town Brooklyn
(If outside city or town limits, write RURAL and give town)
(d) Street No. 718 21st Ave.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Shirley Reiss

3 (b) If veteran, name war	3 (c) Social Security Account No.
M	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-4-43

8. AGE: Years	Months	Days	If less than one day
2.	3	29	hr. min.

9. Birthplace N.Y. (Town, county, and state)
10. Usual Occupation.....
11. Industry or business.....

FATHER
12. Name Harry Reiss
13. Birthplace N.Y.

MOTHER
14. Maiden Name Blanche Hoffman
15. Birthplace N.Y.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11/3/45 (month) (day) (year)
(c) Cemetery or crematory NEW MONTEFIORE
Location SPRINGFIELD. LONG ISLAND, N.Y.

18 (a) Funeral director Nathan Cook Inc
(b) Address 1217 St Paul St

NOV 3 - 1945 Huntington Williams, M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION A

20. DATE OF DEATH Nov. 3 1945 at 12:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 23 1945 to Nov 3 1945 and that I last saw her alive on Nov. 3 1945

Immediate cause of death	Duration
Cardiac Failure + Circulatory Collapse	
Due to: Post Operative Atelectasis + Congenital Heart Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation November 1, 1945
Major findings of operation: Congenital Heart Disease
of autopsy.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....
23. Signature J. E. Conwell M.D.
Address Johns Hopkins Hospital Date signed 11/3

VS 150

X

G338:28

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G338:28 Registered No. 85

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Kilburn & Caton Aves
(c) Hospital or institution: St. Agnes Hospt
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore St Arlow
(If outside city or town limits, write RURAL and give town)
(d) Street No. 320 So Fulton St
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mr. Jessie Schmidt (Jesse Schmidt)

3 (b) If veteran, name war None

3 (c) Social Security Account No. None

4. Sex M.

5. Color or race W

6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife Ellie Schmidt

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 6, 1886

8. AGE: Years 59 | Months 3 | Days 28 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Lathery

11. Industry or business Retired

FATHER
12. Name John Schmidt
13. Birthplace Germany

MOTHER
14. Maiden Name Yokenbern
15. Birthplace Germany

16 (a) Informant Daughter, Mrs Agnes Smith
(b) Address 206 So Fulton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 6, 1945 (month) (day) (year)

(c) Cemetery or crematory London Park
Location Baltimore Maryland

18 (a) Funeral director George L. Schwab
(b) Address 2101 Frederick Ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

NOV 1 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/3 19 45 at 5:23 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/2 19 45 to 11/3 19 45 and that I last saw h[illegible] alive on 11/3 19 45.

Immediate cause of death Cardiac failure — Duration

Due to Arteriosclerosis — Duration

Erysipelas, Hospital — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Cliff Rowitt Jr. M. D.
Address St. Agnes Hosp Date signed 11/3/45

Ruth'd X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G33829 ✓ G33829

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1323 E. North Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) 5 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1323 E. North Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Domenico Sorrentino

3 (b) If veteran, name war None
3 (c) Social Security Account No. None

4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Antoinette Aiello
6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) April 10, 1878

8. AGE: Years 67 | Months 6 | Days 24 | If less than one day ###### min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Shoe maker
11. Industry or business Repairing Shoes

FATHER
12. Name Frank Sorrentino
13. Birthplace Italy

MOTHER
14. Maiden Name Guiseppa Mannisi
15. Birthplace Italy

16 (a) Informant Stephen J. Maggio (Nephew)
(b) Address 1640 N. Wolfe Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/6/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Balto: Md
16 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue
Huntington Williams, M.D.

18 (a) 1945 (Dated by registrar) (b) 0 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 3rd., 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1, 1945, to Nov. 3 1945; and that I last saw h~~is~~ alive on Nov. 3, 1945.

	Duration
Immediate cause of death Cerebral Hemorrhage	3 days
Due to Hypertensive Arterio-Sclerosis Renal Disease.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M.D.
Address 1331 E. Chase Ave. Date signed 11-3-45

Object are is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G33830

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G33830 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1828 Hope Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1828 Hope Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Kunigunda Mihm

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife John Adam Mihm
6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) March 7th, 1863

8. AGE: Years	Months	Days	If less than one day
82	7	24	####### min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name John Wunner
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Kalbskoff
15. Birthplace Germany

16 (a) Informant John A. O'Brien
(b) Address 28A Oak Grove Apt. Cedar Dr.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/5/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Balto. Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Eastern Avenue

19 (a) 1945 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 31st 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/1 1945, to Oct 31 1945, and that I last saw her alive on Oct 31 1945.

Immediate cause of death: Cerebral Hemorrhage

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration
several years

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Evl Smith
Address 1223 E. North Date signed 11/2/45

X

Please write plainly, using ink. Physicians: please write the causes of death clearly and legibly. Be sure that the correct age is especially important.

G33831 BALTIMORE CITY HEALTH DEPARTMENT ✓ G33831

CERTIFICATE OF DEATH 124B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Aisquith
(c) Hospital or institution: 9r

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1514 Aisquith
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Anna E. January

3 (b) If veteran, name war None
3 (c) Social Security Account No. None

4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife George H. January
6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) June 13, 1894

8. AGE: Years 51 | Months 4 | Days 20 | If less than one day ######## min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Thomas Brooks
13. Birthplace Scotland

MOTHER
14. Maiden Name Ellen E. Foley
15. Birthplace Ireland

16 (a) Informant George H. January
(b) Address 1514 Aisquith Street

17 (a) Burial (b) Date thereof 11/6/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) [illegible] Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 2 1945, at 3 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 10 1945 to Nov. 2 1945 and that I last saw h[illegible] alive on Nov 2 1945

Immediate cause of death Cerebral Hemorrhage.
Due to Purpura Hemorrhagica
Due to Hepatic Cirrhosis.
Other Conditions
(Include pregnancy within 3 months of death)

Duration
Sudden
2 yr.
?

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph E. Bennett M.D.
Address 1206 E. Preston St. Date signed 11/3/45

VS 150

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G33832 BALTIMORE CITY HEALTH DEPARTMENT ✓ G33832

CERTIFICATE OF DEATH 937 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette & John St.
(c) Hospital or institution: Hospital for Women of Maryland - 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 68 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore. (If outside city or town limits, write RURAL and give town)
(d) Street No. 20 Whitfield Rd. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) **FULL NAME** Helen Baltzell Swope.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. married.

6 (b) Name of husband or wife Harry Fowler Swope
6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) 8-28-1877

8. AGE: Years 68 | Months 2 | Days 5 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Housemaker.

11. Industry or business

FATHER 12. Name Bolling Selden.
13. Birthplace Virginia.

MOTHER 14. Maiden Name Susan Baltzell
15. Birthplace Baltimore, Md

16 (a) Informant Hospital Admission
(b) Address Record.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 5 1945 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md

18 (a) Funeral director Henry W. Jenkins Sons Co
(b) Address 1911 E. Fayette & 1 N. Eutaw St.

19 (a) NOV 4 - 1945 (Date rec'd by registrar) Huntington Williams Mgr

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 2 1945, at 6:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 6 1945 to Nov 2 1945, and that I last saw her alive on Nov 2 1945.

Immediate cause of death: Ventricular fibrillation — Duration: 1 minute

Due to: Coronary occlusion — Duration: 48 hours

Due to: Arteriosclerotic Heart Disease — Duration: 5 years

Other Conditions: Arteriosclerosis, General, Cardiac failure, chronic

(Include pregnancy within 3 months of death)

Date of Operation

Major findings of operation

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William H. Hemmeter, M. D.
Address Hosp. for Women of Md Date signed 11-2-45

G338.43 ✓ G338.43

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170C

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3208 Monchester Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Samuel M. Frenkil

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Dora

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 1900

8. AGE: Years: 45 | Months | Days | If less than one day: hr. min.

9. Birthplace: Balto Md. (Town, county, and state)

10. Usual Occupation: Contractor

11. Industry or business

FATHER 12. Name: Isaac

FATHER 13. Birthplace: Russia

MOTHER 14. Maiden Name: Jennie

MOTHER 15. Birthplace: Russia

16 (a) Informant: Wife

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-4-45 (month) (day) (year)

(c) Cemetery or crematory: Beth Tefiloh

Location: Windsor Mill Rd

18 (a) Funeral director: Jack Lewis Inc

(b) Address: 1439 E. Balto St

NOV 4 - 1945 (a) (Date rec'd by registrar) (b) Huntington Williams Inc

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 2 1945, at 10:30 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH: Fracture of neck

Due to

Other Conditions: laceration of neck.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Nov 2, 1945 10:30 P M.
(b) Where did injury occur? Bateman & Dennison Sts
(c) Did injury occur at home, on farm, industrial place, in public place? Public place While at work? no
(d) Means of injury Automobile accident.

23. Signature Benedict Skitarelis M.D. Medical Examiner.
Date signed Nov 3, 1945

VS 151

G33834 | BALTIMORE CITY HEALTH DEPARTMENT | G33834 Registered No.

CERTIFICATE OF DEATH

75B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3410 Greenmount Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rose Hack

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Simon
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1902

8. AGE: Years	Months	Days	If less than one day
43			hr. min.

9. Birthplace Lithuania (Town, county, and state)
10. Usual Occupation Nurse
11. Industry or business

FATHER
12. Name (D.) Samuel Sussman
13. Birthplace Lithuania

MOTHER
14. Maiden Name (D.) Annie
15. Birthplace Lithuania

16 (a) Informant Simon Hack
(b) Address 3410 Greenmount

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-4-45 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philad Rd + Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Balto St

19 (a) NOV 4 1945 (Date rec'd by Regtrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 2nd 1945, at 11:30 A.M.

21. I certify that I took charge of the remains described above, held an Insp. & Inq. thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cardiac Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Leon Lee Katz, M.D. Medical Examiner.
Date signed Nov 2 1945

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G338.45 BALTIMORE CITY HEALTH DEPARTMENT G338.45
CERTIFICATE OF DEATH 93E
Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1231 E. Lanvale St.
(c) Hospital or institution: at Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1231 E. Lanvale St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edward J. Roche

3 (b) If veteran, name war: No
3 (c) Social Security Account No. 214-03-6064

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Estella M. Grogan Roche
6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) 1889 12 5

8. AGE: Years 56 | Months 10 | Days 26 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Mantenance Man

11. Industry or business Fair Field Ship Yard

FATHER 12. Name Edward C. Roche
13. Birthplace Baltimore, Md

MOTHER 14. Maiden Name Catherine Berkmeier
15. Birthplace Baltimore, Md

16 (a) Informant Mrs Estella M. Roche
(b) Address 1231 E. Lanvale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 6 45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cemetery
Location 4300 Old Frederick Rd.

18 (a) Funeral director Edwin W. Coughlin & Son
(b) Address 924 E. Eager St.

(a) Date received NOV 4 1945 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 1 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 24 1945, to Nov. 1 1945, and that I last saw him alive on Oct 31 1945.

Immediate cause of death	Duration
Coronary Thrombosis	
Due to	
Due to	
Other Conditions Hypertension	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Jacob Fisher M. D.
Address 823 N. Wolfe St. Date signed 11/2/45

VS 8

G33836 G33836

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95C

Registered No.

Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2815 Cold Spring Lane
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 62 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2815 Cold Spring Lane (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence Centenial Mitchell

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-18-5971

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 15-1879

8. AGE: Years 66y. Months 7 mo. Days 18 da. If less than one day ... hr. ... min.

9. Birthplace Prince Georges County - Maryland. (Town, county and state)

10. Usual Occupation Watchman

11. Industry or business Race Track.

FATHER
12. Name George T. Mitchell
13. Birthplace Prince Georges County.

MOTHER
14. Maiden Name Matilda Crook
15. Birthplace Prince Georges County

16 (a) Informant Katherine Tubby
(b) Address 2815 Cold Spring Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 5, 1945 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore

18 (a) Funeral director Ellis S. White
(b) Address 2340 Cold Spring Lane

19 (a) 1945 (Date rec'd by registrar) (b) Harry Lee Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 2 1945; at 10.10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from December 15 1943 to November 2 1945, and that I last saw h. him alive on 11-2-1945.

Immediate cause of death: Organic Heart Disease — Duration: unknown

Due to

Due to

Other Conditions: Asthma

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chester Pilsard M. D.
Address 2532 Edmondson Ave Date signed 11-2-45

VS 150

G33837 BALTIMORE CITY HEALTH DEPARTMENT G33837
CERTIFICATE OF DEATH 1945
Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3100 W. Baltimore St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3100 W. Baltimore St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Washington Belsinger

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: M.
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Emma F. Belsinger
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 29, 1862

8. AGE: Years 83 | Months 8 | Days 3 | If less than one day hr. min.

9. Birthplace Philadelphia Pa.
(Town, county, and state)

10. Usual Occupation Clothing Designer
11. Industry or business Retired

FATHER
12. Name Philip Belsinger
13. Birthplace New York City

MOTHER
14. Maiden Name Eve V. Holiday
15. Birthplace Unknown

16 (a) Informant Mrs. Harry J. Belsinger
(b) Address 3100 W. Baltimore

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 5 1945 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore

18 (a) Funeral director Frederick A. Cole
(b) Address 1206 W. Baltimore

19 (a) (Date rec'd by registrar) (b) Registrar

NOV 4 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 2, 1945, at 3 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 11 1945, to Nov 2 1945, and that I last saw him alive on Oct 22 1945.

Immediate cause of death: Generalized arteriosclerosis with Bronchiectatic CVD & cerebral — Duration: 6 years
Due to: arteriosclerosis
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leonard Yaffe M.D. M. D.
Address 3100 W. Baltimore St Date signed

NOV 3 1945

G33838

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

G33838 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use write the causes of death clearly and legibly. correct age is especially important. Physicians: please w

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: # 8 W. Cross St.
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) about 5 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. # 8 W. Cross St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) **FULL NAME** Friedericka (Ricke-Barr) Bahr

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Frederick J. Bahr

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): Sept. 10, 1873

8. AGE: Years 72 | Months 1 | Days 22 | If less than one day ____ hr. ____ min.

9. Birthplace: Uslar, Germany (Town, county, and state)

10. Usual Occupation: At Home

11. Industry or business

FATHER
12. Name: William D. Pleiss
13. Birthplace: Uslar, Germany

MOTHER
14. Maiden Name: Caroline Wienekee
15. Birthplace: Uslar, Germany

16 (a) Informant: Mrs. Frieda Thompson
(b) Address: 8 W. Cross St., Balto. 30, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Nov. 5, 1945 (month) (day) (year)
(c) Cemetery or crematory: Madonna [illegible] Cemetery
Location: [illegible] Md. Howard Co

18 (a) Funeral director: A. Howard Evans
(b) Address: 1400 E. Chase St. - Balto. 30 Md.

19 (a) Nov 7 1945 (Date received by Registrar) Huntington Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 2, 1945, at 12:06 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 15 1945, to Nov. 2, 1945, and that I last saw him alive on Nov. 2 1945.

Immediate cause of death: Arteriosclerotic Heart Disease — Duration

Due to: Cardiac Hypertrophy

Due to: Cardiac Decompensation

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Vincent M. Messina M. D.

Address: 1403 S. Charles Date signed 11/2/45

VS 190

G33839

BALTIMORE CITY HEALTH DEPARTMENT X 83a

CERTIFICATE OF DEATH

G33839 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1/2 hour
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Woodlawn (If outside city or town limits, write RURAL and give town)
(d) Street No. 6916 6916 Dogwood Rd (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Garrett Atkinson (Edward Garrett Atkinson)
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Mrs Alice Atkinson
6 (c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) Oct 29 1885

8. AGE: Years	Months	Days	If less than one day
60	—	4	hr. min.

9. Birthplace Centreville, Maryland (Town, county and state)
10. Usual Occupation Assistant Standard Brass
11. Industry or business and Copper Co.

FATHER
12. Name Bradford E. J. Atkinson
13. Birthplace Centerville Maryland

MOTHER
14. Maiden Name Sarah J. Holliday
15. Birthplace Queen Anne County Maryland

16 (a) Informant Mrs. Alice Atkinson
(b) Address 6916 Dogwood Rd. Bdbg. Wdln

17 (a) Burial (b) Date thereof Nov. 5, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemetery
Location Woodlawn, Md.

18 (a) Funeral director E. W. Lemoreaux
(b) Address 4510 Liberty Heights Ave.

19 (a) (Date filed by registrar) Covington Williams Registrar

NOV 4 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 2 1945, at 9:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 2 1945, to Nov. 2 1945, and that I last saw him alive on Nov. 2 1945

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. Szmeluch W. M. D.
Address Mercy Hospital Date signed 11/2/45

X Sanchez

Please write plainly, with unfading ink. Every question must be answered. Where exact information is not obtainable, an approximate statement is required. Do not use abbreviations. Write out the full name of the street and number of the house in which the death occurred. Give the usual residence of the deceased, not the place where he may have been temporarily sojourning at the time of death, unless he had no other residence. If the deceased was a married woman, write her own given name and surname, not those of her husband. The statements regarding parentage and birthplace should be as definite as possible. Write the name of the county in every case. Write the name of the city or town in which the deceased was born, if known. Street age is especially important. Physicians: please write the causes of death clearly and legibly.

G33840

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G33840 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4100 Halbad Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4100 Halbad ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Catherine J. Rocke

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife John Rocke

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 24, 1862

8. AGE: Years	Months	Days	If less than one day
83	8	9	hr. min.

9. Birthplace Quebec, Canada
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name — Rickney
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Harriet Summers
(b) Address 4100 Halbad ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 5, 1945 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balt.

18 (a) Funeral director George A. Dailey
(b) Address 2nd Howard & Fayette Sts

19 (a) (Date received by registrar) (b) Huntington-Williams

NOV 4 - 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 5 1945, at 1:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1944, to Nov 1 1945, and that I last saw her alive on Nov 1 1945.

Immediate cause of death	Duration
Respiratory failure	
Due to Generalized arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature J. Sborofsky M.D.
Address 601 N. Monroe St Date signed 11/3/45 M. D.

Sborofsky

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be answered or a satisfactory explanation given. Use black ink. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

633841

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

633841 / 93a Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1525 W. Lombard St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 27 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1525 W. Lombard St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mattie S. Minter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Late B. Frank Minter

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 18, 1861.

8. AGE: Years	Months	Days	If less than one day
84	9	14	hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Simon Hancock
13. Birthplace Va.

MOTHER
14. Maiden Name Betty Ann Minter
15. Birthplace Va.

16 (a) Informant Mr. Robert Fox
(b) Address 1525 W. Lombard St.

17 (a) Removal (b) Date thereof Nov. 4/45.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Fairview Cemetery
Location Roanoke, Va.

18 (a) Funeral director Harry H. Luttrell
(b) Address 4101 Simpson Ave.

19 (a) 1945 (b) Huntington, W. Va.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 2/45. 19 at 4a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 9 1945 to Nov. 1 1945. and that I last saw h[illegible] alive on Nov 1 1945

Immediate cause of death	Duration
Acute Myocarditis	
Due to Chronic arterio Sclerosis	
Due to Infirmary of age	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Clarence E. Mackee M. D.
Address 3900 Garrison Blvd Date signed Nov. 2 45

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be answered by writing or printing in the proper space; where none exists, write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

G33842 G33842

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dukeland & Raymon Ave
(c) Hospital or institution:
West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Lansdowne
(If outside city or town limits, write RURAL and give town)
(d) Street No. 139 American Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edgar Haupt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ada W. Haupt

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 10, ~~1888~~ 88

8. AGE: Years 57 56 | Months 2 | Days 22 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Asst. Fire Chief

11. Industry or business Edgewood Arsenal

FATHER
12. Name Haupt
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace Md.

16 (a) Informant Mrs. Ada W. Haupt.
(b) Address 139 American Ave. Lansdowne

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 5/45. (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Rd.

18 (a) Funeral director Harry B. Lucke
(b) Address 4101 Edmondson Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

Huntington Williams (Asst)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/2 1945 at 2 50

21. I certify that death occurred on the date above stated; that I attended deceased from 11/1 1945, to 11/2 1945, and that I last saw him alive on 11/2 1945

Immediate cause of death Cerebral Diabetic Coma

Due to Diabetic Mellitus

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Rudolph Baldwin
Address West Baltimore General Hospital Date signed 11/2/45

VS 150

DISEASES WHICH PEARL, WITH UNIFORMS INC. SWEEP... correct age is especially important. Physicians: please write t... every death or information known to certify regarding...

G338:3

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1927

G338:3 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1131 Valley St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1131 Valley St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Elizabeth Gaffney

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	widow

6 (b) Name of husband or wife Michael J.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 6. 1859

8. AGE: Years	Months	Days	If less than one day
68	1	26	hr. min.

9. Birthplace Balto
(Town, county, and state)

10. Usual Occupation -

11. Industry or business

FATHER 12. Name Carl Pinning
13. Birthplace Germany

MOTHER 14. Maiden Name Anna Rauffie
15. Birthplace Germany

16 (a) Informant Anna Gaffney
(b) Address

17 (a) Burial (b) Date thereof Nov. 5 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 914 Greenmount Ave

19 (a) Huntington Williams, M.D. Registrar
(Date paid by registrar)

4-1945 Vs 150 Dp. W. Garrity

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 2 1945, at 6:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 25 1945, to Nov 2 1945, and that I last saw her alive on Nov 1 1945.

Immediate cause of death	Duration
Coronary artery Thrombosis	2 days
Due to Myocardial degeneration	? years
Due to Valvular heart disease	? years
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William R. Bagley M.D.
Address 106 Eddelp St Date signed 11/3/45

M. D. R. 1268-9

G33844

HEALTH DEPARTMENT—CITY OF BALTIMORE

G33844

CERTIFICATE OF DEATH

1246

1. PLACE OF DEATH Southern Hospital - GREENMOUNT 125 STS Registered No.

CITY OF BALTIMORE: (No. 400 Ellicott Ln St., 12 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME M. Gould Furlong - FURLONG -

(a) Residence: No. 442 Ellicott Ln. St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of MARGUERITE S. FURLONG

6. DATE OF BIRTH (month, day, year) 1898

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
47 4/6			

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. WATCHMAN.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Balto., MD

FATHER

13. NAME MICHEAL FURLONG

14. BIRTHPLACE (city or town) (State or country) Balto., MD.

MOTHER

15. MAIDEN NAME MARY BYRNES

16. BIRTHPLACE (city or town) (State or country) Balto. MD.

17. INFORMANT MRS. M. S. FURLONG

(Address) 442 ELLICHESTER Ave

18. BURIAL, CREMATION, OR REMOVAL

Place CATHEDRAL CEM. Date NOV. 5, 1945

19. UNDERTAKER MARY M. WIEDEFELD

(Address) 521 E. 22ND ST.

20. FILED NOV 4 1945, 19

Huntington Williams, Registrar.

OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) November 1, 1945

22. I HEREBY CERTIFY, That I attended deceased from October 15, 1945 to November 1, 1945

I last saw him alive on October 30, 1945 Death is said to have occurred on the date stated above, at 4:30 P.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Carcinoma Liver.	1940
Chronic Myocarditis	1943
Chronic Interstitial Nephritis	1943
Other contributory causes of importance:	
Ascites	1945
Toxemia	1945

Name of operation None Date of

What test confirmed diagnosis? X-Ray Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No If so, specify

(Signed) F. W. Bishop M. D.

(Address) 501-503 Shenandoah

G33845 BALTIMORE CITY HEALTH DEPARTMENT G33845
CERTIFICATE OF DEATH 159
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 days
(e) Length of stay in Baltimore (yrs., mos., or days) 23 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 227 Myrtle Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country No.

3 (a) FULL NAME Gertrude Bell

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-10-45

8. AGE: Years	Months	Days	If less than one day
		23	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Eddie Carson Bell
13. Birthplace Chesterfield S.C.

MOTHER
14. Maiden Name Ethel Jones
15. Birthplace Greensboro, N.C.

16 (a) Informant Ethel Bell
(b) Address 227 Myrtle Ave.

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 11/4/1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Carbon Cemet. Location Westport Md

18 (a) Funeral director Mrs. Kate R. Williams
(b) Address 3221 N. Schroeder St.

19 (a) 1945 (Registered by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 2, 1945, at 6:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 10, 1945 to Nov. 2, 1945, and that I last saw her alive on Nov. 2 19 1945

Immediate cause of death	Duration
(a) Premature (7 Mo)	Stillborn
Due to (b) Pulmonary Atelectasis	
Due to (c)	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 11/4/45

Please write plainly with pen or typewriter, using unfading ink. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G33846

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2 W. University Pkway.
(c) Hospital or institution:
Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) One
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2 W. University Pkway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clinton Ellis Colbert

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 265-09-4443

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 1 1893

8. AGE: Years 52 Sb ? | Months 3 | Days 3 | If less than one day ... hr. ... min.

9. Birthplace Virginia Fredericksburg
(Town, county and state)

10. Usual Occupation Mutual Clerk Retired

11. Industry or business Cashier

FATHER
12. Name James Beverly Colbert
13. Birthplace Massaponax, Va.

MOTHER
14. Maiden Name Maybelle Hayes Ellis
15. Birthplace Fredericksburg Va.

16 (a) Informant Thayne Williams
(b) Address 2 W University Pkway.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11/4/45 (month) (day) (year)
(c) Cemetery or crematory Fredericksburg Va.
Location

18. (a) Funeral director William J. Tickner & Sons
(b) Address North & Pennsylvania Aves

19 - 5 - 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 4, 1945, at 8 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/4/1945 to 11/4/1945 and that I last saw him alive on 11/4/1945

Immediate cause of death Cerebral Hemorrhage — Duration

Due to Hypertension - Cardio - vascular disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 0

Major findings of operation: 0

of autopsy: 0

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Frank Simpkins, Jr.
Address Union Memorial Hospital Date signed 11/4/45

Approved by: C. C. Sabatini M.D.

633847

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. 633847

Please write plainly, with unfading ink. Use typewriter if possible. Do not abbreviate. Give the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Bon Secours Hosp
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 1/2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town ~~106 S Green~~ Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 106 S Greene St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Roy L. Herring
3 (b) If veteran, name war ?
3 (c) Social Security Account No. 217-12-0943

4. Sex Male | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Alice
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) R(?)
8. AGE: Years 48 | Months | Days | If less than one day hr. min.
9. Birthplace ? (Town, county, and state)
10. Usual Occupation Unknown,
11. Industry or business

FATHER
12. Name John W Herring
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant J. Jenkins
(b) Address 106 W Green St.
17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof Nov 6-45 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Redwood Rd
18 (a) Funeral director Joseph Rasmuskas Inc
(b) Address 60 E Washington St.
19 (a) 11-5-1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-3 1945 at 4:30 P.M
21. I certify that death occurred on the date above stated; that I attended deceased from 9-21 1945 to 11-3 1945 and that I last saw h. alive on 11-3 1945
Immediate cause of death Adeno-Carcinoma of Sigmoid & Metastasis to Mesenteric Lymph Nodes — Duration 4 mos.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Richard C. Hayden M. D.
Address Bon Secours Date signed 11-3-45

VS 150

6338:8

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

Registered No. 6338:8

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2044 Wilkens ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 0
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2044 Wilkens Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME David L. Huffman

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. 217-09-5927

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	Widowed

6 (b) Name of husband or wife Zuba.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years	Months	Days	If less than one day
61			hr. min.

9. Birthplace Virgina (Town, county, and state)
10. Usual Occupation Box Maker
11. Industry or business

FATHER
12. Name ?
13. Birthplace Virgina

MOTHER
14. Maiden Name ?
15. Birthplace Virgina

16 (a) Informant Anna Shackelford
(b) Address 2044 Wilkens Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 7-45 (month) (day) (year)
(c) Cemetery or crematory Linville Cem.
Location Virginia

18 (a) Funeral director Bernard Hale
(b) Address 121 E West St

(a) Date received by registrar NOV 5 - 1945 Huntington Williams MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/4 1945 at 2:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from August 1 19 45 to Nov 4 1945, and that I last saw h[illegible] alive on Nov. 4 1945

Immediate cause of death	Duration
Carcinoma of stomach	6 mons.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benjamin Miller M.D.
Address 2070 Wilkens ave. X Date signed 11/4/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. Be sure correct age is especially important.

6338-9

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 98

6338-9 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address West Balto Gen
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 wks
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1537 Cole St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Victorine Jones

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. W.

6 (b) Name of husband or wife Morris

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 29-1877

8. AGE: Years 68 | Months 2 | Days 7 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name George T Rathrock
13. Birthplace Balto

MOTHER
14. Maiden Name Susannah Burden
15. Birthplace Baltimore

16 (a) Informant Robert Rathrock
(b) Address 1537 Cole St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/6/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk. Cem
Location Baltimore

18 (a) Funeral director Wm Cook Inc
(b) Address 1217 St Paul St

NOV 5 - 1945 (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 3, 1945, at 1100 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-26-1939 to 11-3-1945, and that I last saw h-r alive on Nov 3 1945

Immediate cause of death Cardiac failure

Due to Post-operative shock

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Nov 3-1945

Major findings of operation: Malignancy of Rt lung, stone and gallbladder

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. D. Taylor M. D.

Address W. B. Jen. Hosp Date signed Nov 3-45

Registrar Washington Hollands, M.D.

G338_0 — BALTIMORE CITY HEALTH DEPARTMENT — G33850

CERTIFICATE OF DEATH 937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2613 Greenmount Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2603 Greenmount Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sarah A. Robinson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6. (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Alfred

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 31, 1883

8. AGE: Years 62 | Months 0 | Days 1 | If less than one day hr. min.

9. Birthplace Baltimore Co. Md (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER 12. Name James Barrett
13. Birthplace Ireland

MOTHER 14. Maiden Name Anna Swift
15. Birthplace Ireland

16 (a) Informant Margaret Trimble
(b) Address 2613 Greenmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/6/45 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore, Md

18 (a) Funeral director Wilmon Koch Co.
(b) Address 1217 E. Fayette St

19 (a) NOV 5 - 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 2 1945, at 2 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 2nd. 1945 to Nov. 2nd. 1945 and that I last saw h__ alive on Nov. 2nd. 1945

Immediate cause of death	Duration
Myocardial Insufficiency	about 1 yr.
Due to Arteriosclerosis	about 3 yr.
Due to -------	
Other Conditions None	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jas. W. Margetrogh Jr. M.D.
Address 401 E. 25th. St. Date signed 11/3/45.

VS 150

Please write plainly with pen or pencil. Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

633851

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

633851

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 910 Montpelier St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME James W. Clayton

3 (b) If veteran, name war: no
3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	M

6 (b) Name of husband or wife Etta Clayton
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) March 4, 1877

8. AGE: Years	Months	Days	If less than one day
68	7	27	hr. min.

9. Birthplace Baltimore City Md. (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER 12. Name Jas. Wm. C. Clayton
13. Birthplace Unknown

MOTHER 14. Maiden Name ?
15. Birthplace

16 (a) Informant James W Clayton (son)
(b) Address 900 E. 30th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/6/45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn Md.

18 (a) Funeral director Filbert Lodge Inc
(b) Address 217 E Lexington St.

19 (a) (Date rec'd by registrar) NOV 5 - 1945 (b) Registrar

Gaithersburg, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 1 1945 at 7 39 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1 1945 to Nov 1 1945 and that I last saw him alive on Nov 1 1945

Immediate cause of death Coronary thrombosis — Duration ?

Due to Arteriosclerotic heart disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William H. Little M. D.

Address Union Memorial Hospital Date signed 11-1-45

X

63385

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83B

Registered No. 63385

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be entered. Be sure correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3106 Belmont Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Emma Bangs

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	W.

6 (b) Name of husband or wife Harry Z.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 12-1893

8. AGE: Years	Months	Days	If less than one day
52	5	12	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Telephone Operator
11. Industry or business C & P Phone Co.

FATHER
12. Name Edward Griffin
13. Birthplace Balto

MOTHER
14. Maiden Name Mary Graham.
15. Birthplace Ireland

16 (a) Informant Dorothy A Bangs.
(b) Address 3106 Belmont Ave

17 (a) Burial (b) Date thereof 11-8-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cem
Location Baltimore

18 (a) Funeral director Wm Cook Inc
Address 1367 St Paul St.

19 (a) NOV 5 1945 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 4 1945, at 2:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19.

Immediate cause of death	Duration
Broncho-pneumonia	
Due to Cerebral embolism (right) with Left Hemiplegia	
Due to	
Other Conditions Auricular fibrillation.	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. M. Caudill M. D.
Address Maryland General Hosp. Date signed 11-4-45

VS 150

633853

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 633853

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address REDWOOD & GREENE
(c) Hospital or institution:
UNIVERSITY HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County HOWARD.
(c) City or town RURAL - HARRIOTTSVILLE
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? NO. (Yes or No)
If yes, name country

3 (a) **FULL NAME** JENNIE NICHOLS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	BLACK	MARRIED

6 (b) Name of husband or wife EUGENE NICHOLS
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1889

8. AGE: Years	Months	Days	If less than one day
56			hr. min.

9. Birthplace MARYLAND (Town, county, and state)
10. Usual Occupation HOUSE WIFE
11. Industry or business

FATHER
12. Name GEORGE CONWAY
13. Birthplace MARYLAND

MOTHER
14. Maiden Name ALICE THEEN
15. Birthplace MARYLAND

16 (a) Informant HOSPITAL RECORDS
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-6 1945 (month) (day) (year)
(c) Cemetery or crematory West Liberty Md
Location Ellicott City Md

18 (a) Funeral director F. C. Heimbothom
(b) Address Ellicott City Md

NOV 5 - 1945 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/2 1945, at 10 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/30 1945 to 11/2 1945, and that I last saw her alive on 11/2 1945

Immediate cause of death UNKNOWN.

Due to

Due to

Other Conditions ARTERIO - SCLEROTIC CARDIO VASCULAR DISEASE
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John H. Dennis

Address Mercy Hospital Date signed 11/3/45

VS 150

633854

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

633854 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: St. Bald. Gen. Hospital 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) 20 years ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1508 Curtis Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Adam Holowachuk

3 (b) If veteran, name war

3 (c) Social Security Account No. 21305-5107

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1891

8. AGE: Years	Months	Days	If less than one day
54			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER 12. Name Jeko Holowachuk
13. Birthplace Russia

MOTHER 14. Maiden Name Martha —
15. Birthplace Russia

16 (a) Informant Adam Holowachuk
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School NOV 3 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 NOV 5 1945 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 31 1945 at 9:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 17 1945 to Oct 31 1945 and that I last saw him alive on Oct 31 1945.

Immediate cause of death Carcinoma of stomach & metastasis to the liver.

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Gastric Carcin. & metast.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Erlich M. D.
Address 1213 Light St. Date signed 11-1-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use figures for dates. Be sure to write the causes of death clearly and legibly. Physicians: please write correct age in especially important.

VS 150

3055

633855

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 167

633855 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 270 N. Exeter St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julius Tyus

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1895

8. AGE: Years	Months	Days	If less than one day
50			hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School NOV 3 1945

18 (a) Funeral director Commissioner of Health
(b) Address
1945 NOV 5 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 23, 1945, at 12:30 M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Stab wound left chest penetrating abdominal cavity
Hemorrhage in abdomen
Perforation descending Colon

Other Conditions Early peritonitis
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury October 22, 1945 M.
(b) Where did injury occur? Broadway & Eden Sts
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury Stab wound

23. Signature Benedict Skotarek M.D.
Medical Examiner.
Date signed 10/23/45

VS 151

13056

633856

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 159

633856 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore River Harvard
(c) Hospital or institution: Johns Hopkins Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 7 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5609 Belvoir Rd # 14
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Rosenberg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W.	Baby

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 23, 1945

8. AGE: Years	Months	Days	If less than one day
		6	hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Mrs. Rosenberg
13. Birthplace Mdle Md.

MOTHER
14. Maiden Name Ovrette Cagler
15. Birthplace Balto Md

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School NOV 3 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) NOV 5 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/29/1945, at 7 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/25/1945 to 10/29/1945 and that I last saw h[illegible] alive on 10/29/1945

Immediate cause of death Pneumonia

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 355 Eastern Ave Date signed 10/30/45

3057

X

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

633857

BALTIMORE CITY HEALTH DEPARTMENT X ✓ 633857
CERTIFICATE OF DEATH 159 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Ad
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore Essex
(If outside city or town limits, write RURAL and give town)
(d) Street No. 41 Edgewater Apt One (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Judy Lynn Staley
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 24 1945
8. AGE: Years | Months | Days 3 day | If less than one day hr. min.
9. Birthplace Baltimore Md (Town, county and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Ernest Staley
13. Birthplace N. C.

MOTHER
14. Maiden Name Ivy Belle Anderson
15. Birthplace N. C.

16 (a) Informant Ivy Belle Staley
(b) Address 41 Edgewater Apt A Catonsville

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School NOV 3 1945
18 (a) Funeral director Commissioner of Health
(b) Address
19 NOV 5 1945 (b) Huntington Williams M.D. Registrar
(When rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 26 1945 at 1 P M
21. I certify that death occurred on the date above stated; that I attended deceased from Oct 24 1945 to Oct 26 1945 and that I last saw h[illegible] alive on Oct 26 1945
Immediate cause of death Cardiac Failure — Duration
Due to Prematurity
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Hemorrhage in Pericardium

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature [illegible] M. D.
Address 230 Eutaw St Date signed 10/27/45

Please write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

VS 8

3058

X

633855

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 633855

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 233 E. University Parkway
(c) Hospital or institution:
Temple Court Apartments
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 233 E. University Pkwy
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FREDERICK WILLIAM BRUNDICK

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 217-14-0105A

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Katherine S. Brundick

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 18, 1867

8. AGE: Years	Months	Days	If less than one day
78	5	14	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Henry Brundick
13. Birthplace Germany

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Miss Matilda Brundick
(b) Address 233 University Parkway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-5-45 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 NOV 5 - 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION 3.10PM

20. DATE OF DEATH November 1, 1945

21. I certify that death occurred on the date above stated; that I attended deceased from June 1943 to Nov 1st 1945
and that I last saw him alive on Nov 1st 1945

Immediate cause of death	Duration
Coronary thrombosis	
Due to Myocarditis	
Due to Arteria-Sclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ira E. Whitehill M. D.
Address 230 E. University Pkwy Date signed Nov 2nd 45
(9.0m)

VS 150

33859

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

169 ✓

Registered No. 33859

33859

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) d. o. a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1003 S. Belnord Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Francis or Frank Kowalski

3 (b) If veteran, name war: NR 2

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feby 6 1922

8. AGE: Years 23 | Months 8 | Days 28 | If less than one day hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation Rubber moulder

11. Industry or business

FATHER
12. Name Franke Kowalski
13. Birthplace Balto Md.

MOTHER
14. Maiden Name Mary Chester
15. Birthplace Balto Md

16 (a) Informant Mrs. Mary Kowalski
(b) Address 1003 S. Belnord.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 7 / 45 (month) (day) (year)
(c) Cemetery or crematory Balto National Cem
Location Fred. Road.

18 (a) Funeral director Stephen J. Feathourstone Inc.
(b) Address 1000 S. Kenwood Ave

19 NOV 5 - 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 4, 1945, at 3:20 A. M.

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Complete transection of body at abdomen and chest

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 1-4

(a) Date of injury 11-4-45 at 1150 A. M.
(b) Where did injury occur? P. R. R. - Baton & Hudson sts.
(c) Did injury occur at home, on farm, industrial place, in public place? Public. While at work? No.
(d) Means of injury. Struck by train.

23. Signature Benedict Skitarelic M.D. Medical Examiner.
Date signed November 4, 1945.

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

633850

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46a

Registered No. 633850

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be entered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ mo
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2422 Keyworth Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Nathan Gilman

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-09-5001

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Late Rebecca

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 5, 1884

8. AGE: Years 61 | Months 9 | Days 29 | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Foreman

11. Industry or business

FATHER
12. Name Joseph Gilman
13. Birthplace Russia

MOTHER
14. Maiden Name Rachel ?
15. Birthplace Russia

16 (a) Informant Jacob Epler
(b) Address 1415 N Chestnut

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 5, 1945 (month) (day) (year)
(c) Cemetery or crematory Beth Tfiloh Cemetery
Location Windsor Mill Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) (Date rec'd by registrar) (b)

NOV 5 - 1945

Registrar Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH November 4 1945, at 1.40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 20 1945 to Nov. 4 1945 and that I last saw h[illegible] alive on Nov. 4 1945.

Immediate cause of death: Carcinoma of esophagus. — Duration: 2 yrs

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature [illegible] M. D.
Address Union Memorial Hospital Date signed 11-4-45

X

G33861

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161a

G33861 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address North Broadway
(c) Hospital or institution Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 24 hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Church Home & Hosp
(If outside city or town limits, write RURAL and give town)
(d) Street No. 614 N. Lakewood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby girl Barrenstube

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex female | 5. Color or race white | 6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife none

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days | If less than one day 24 hr. min.

9. Birthplace Church Home & Hosp
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Andrew Joseph Barrenstube
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Dorothy Leda Seib
15. Birthplace Washington D.C.

16 (a) Informant Church Home Hosp.
(b) Address North Broadway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 5-45 (month) (day) (year)
(c) Cemetery or crematory Pakwood Cem.
Location Taylor Ave.

18 (a) Funeral director John G. Miller
(b) Address 233 Jefferson St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

vs NOV 5 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-3-45 19 , at 1:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/1 1945 to 11/2 1945 and that I last saw h alive on 11/2 1945

Immediate cause of death	Duration
Bilateral atelectasis	
Due to	
Due to	
Other Conditions cerebral edema Ecentric dilatation	

(Include pregnancy within 3 months of death).

Date of operation

Major findings of operation:

of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank M. Shipley M. D.
Address Church Home & Hosp. Date signed 11-4-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G33862

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G33862 Registered No. 170 C

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 874 Carroll Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Donnelly

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: married.
6 (b) Name of husband or wife: Catherine L.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): Jan 13, 1885
8. AGE: Years 60 | Months 1 | Days 26?1 | If less than one day hr. min.
9. Birthplace: Baltimore, Md. (Town, county and state)
10. Usual Occupation: Machinist
11. Industry or business: B & O RR.

FATHER
12. Name: Bernard Donnelly.
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Elizabeth
15. Birthplace: Baltimore Md.

16 (a) Informant: Mrs. Catherine L. Donnelly
(b) Address: 874 Carroll St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/7/45 (month) (day) (year)
(c) Cemetery or crematory: London Park Cem
Location: 3801 Hedgeley Ave.

18 (a) Funeral director: John F. Cowan & Son
(b) Address: 901-03 Fulton St.

19 (a) (Date rec'd by registrar) (b) [illegible] Registrar

VS 451

MEDICAL CERTIFICATION

20. DATE OF DEATH November 4, 1945, at 1:00 P. M.

21. I certify that I took charge of the remains described above, held an ____ thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Skull fracture
Due to: Subdural Hemorrhage
Other Conditions:
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-3-45 at 10:30 A. M. 21-2
(b) Where did injury occur? Fulton & Carroll Sts
(c) Did injury occur at home, on farm, industrial place, in public place? Public. While at work? No.
(d) Means of injury: Pedestrian struck by Auto

23. Signature: Benedict Shtarbe M.D. Medical Examiner.
Date signed November 4, 1945.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G33863

HEALTH DEPARTMENT—CITY OF BALTIMORE

G33863

CERTIFICATE OF DEATH

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 418 W. Lexington St., Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ... How long in U. S. If of foreign birth? ... yrs. ... mos. ... da.

2. FULL NAME Mary Anna Cayer

If U. S. Veteran specify WAR ...

(a) Residence: No. 835 W. Lombard St. St., ... Ward.

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
F	W	Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, year) Oct 10, 1945

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		23	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. ...

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. ...

10. Date deceased last worked at this occupation (month and year) ...

11. Total time (years) spent in this occupation ...

12. BIRTHPLACE (city or town) (State or country) Baltimore Maryland

FATHER

13. NAME Arthur Cayer

14. BIRTHPLACE (city or town) (State or country) Balto Md

MOTHER

15. MAIDEN NAME Norma Sheldon

16. BIRTHPLACE (city or town) (State or country) Balto Md.

17. INFORMANT Norma Cayer

(Address) 835 W. Lombard St

18. BURIAL, CREMATION, OR REMOVAL

Place Mt Olivet Cem. Date 11/5/ 1945

19. UNDERTAKER John A. Cowan & Son

(Address) 901-03 Baltimore St

20. FILED ... 19... Registrar.

NOV 5 - 1945

Remington for Baltimore

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Nov. 3, 1945

22. I HEREBY CERTIFY, That I attended deceased from Nov. 2, 1945, to Nov. 3, 1945

I last saw him alive on Nov. 3, 1945 Death is said to have occurred on the date stated above, at 8.20 a.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Pneumonia, Lobar	Nov 1
Other contributory causes of importance:	

Was an operation performed? ... Date of ...

For what disease or injury? ...

Name of operation ...

What test confirmed diagnosis? ... Was there an autopsy? ...

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ... Date of injury ..., 19...

Where did injury occur? ...

(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place ...

Manner of injury ...

Nature of injury ...

24. Was disease or injury in any way related to occupation of deceased?

... If so, specify ...

(Signed) Leonard Yaffe, M. D.

(Address) Volunteer by Lebanon Hosp

Nov. 3, 1945

X

State CAUSE OF DEATH in plain terms, so that OCCUPATION is very important. See instructions on back of certificate.

G33864

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

G33864 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2229 E North Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 82 0 19

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2229 E North Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah R Henry

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex: female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 14, 1863

8. AGE: Years 82 | Months 0 | Days 19 | If less than one day: hr. min.

9. Birthplace Baltimore maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Joseph Sullivan
13. Birthplace maryland

MOTHER
14. Maiden Name Sarah Stebling
15. Birthplace maryland

16 (a) Informant Mr Howard E Henry
(b) Address 1933 E Thirty second St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-6-1945 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location E North Ave & Rose St

18 (a) Funeral director Albert L Kilby Jr
(b) Address 1606 N Chester Street

19 NOV 5 - 1945 (b) Huntington Williams Registrar
(Date rec'd by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 3rd 1945 at 3.45 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 16 1945 to Nov 3rd 1945 and that I last saw h[illegible] alive on Nov 2 1945

Immediate cause of death	Duration
Acute Cardiac Dilatation	2 days
Due to Arteriosclerosis	3 yrs.
Ch Valv. Heart Dis.	
Due to ✓	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C N Mezger M.D.
Address 1500 E 33rd Date signed 11/5/45

X

CERTIFICATE CORRECTED 9-10-49 Patson ✓ G33865

G33865

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G33865

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1120 Brevard St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1120 Brevard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Andrew Dotson

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-09-6475

4. Sex: male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mattie C. Dotson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 1, 1892

8. AGE: Years 53 | Months 10 | Days 2 | If less than one day hr. min.

9. Birthplace Anderson Co. S.C. (Town, county, and state)

10. Usual Occupation Elevator Operator

11. Industry or business

FATHER
12. Name George H. Dotson
13. Birthplace Anderson, S.C.

MOTHER
14. Maiden Name Emma Poole
15. Birthplace Greenville, S.C.

16 (a) Informant Mattie C. Dotson
(b) Address 1121 Brevard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 5, 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Balto Co. Md.

18 (a) Funeral director Geo. H. Hellen
(b) Address 1631 Druid Hill Ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams, Registrar

NOV 5 - 1945

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 3, 1945, at 4 a.m. P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 10 1945 to Nov 1 1945 and that I last saw him alive on Nov 1 1945

Immediate cause of death: Respiratory failure — Duration

Due to: Cardiovascular renal disease

Due to: Generalized arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. Stanfield, M.D.
Address 601 N. Monroe St Date signed 11/5/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entry of item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G33866

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170c

Registered No. G33866

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: Provident Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) [illegible]
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1137 Carrollton Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter [redacted] Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 23, 192[illegible]

8. AGE: Years	Months	Days	If less than one day
20	5	11	hr. min.

9. Birthplace Gloucester Co. Va
(Town, county, and state)

10. Usual Occupation Returned Soldier

11. Industry or business

FATHER
12. Name Freddie Williams
13. Birthplace Gloucester Co. Va

MOTHER
14. Maiden Name Sarah Fauntleroy
15. Birthplace Gloucester Co. Va

16 (a) Informant Cuffie Tolliferro
(b) Address 113 Carrollton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof NOV. 6, 1945 (month) (day) (year)
(c) Cemetery or crematory Suttonville Va
Location Gloucester Co.

18 (a) Funeral director Wm. Geo. H. Holland
(b) Address 1546 Druid Hill Ave

19 (a) (Date rec'd by registrar) NOV 8 1945 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 3, 1945, at 4:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
* Skull Fracture
Due to: Rupture of heart
Due to: Rupture of liver

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-3-45 at 4:15 P.M.
(b) Where did injury occur? Carey about 30 ft. N. of Monument St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No.
(d) Means of injury (Driver) Auto into Trolley Pole.

23. Signature Benedict Shtarelia M.D.
Medical Examiner.
Date signed November 4, 1945.

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G33867

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G33867

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4844 Pimlico Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4844 Pimlico Road
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Roop Little

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-03-3582

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	widower

6 (b) Name of husband or wife Dora Louise Little
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 22 1874

8. AGE: Years	Months	Days	If less than one day
71	7	12	hr. min.

9. Birthplace Carroll County Md.
(Town, county and state)

10. Usual Occupation Painter
11. Industry or business General house painting

FATHER
12. Name Amos Luther Little
13. Birthplace Carroll County Md

MOTHER
14. Maiden Name Ellen Lovell
15. Birthplace Carroll County Md.

16 (a) Informant Mrs Samuel Amos Little
(b) Address 4844 Pimlico Road

17 (a) Burial (b) Date thereof 11/7/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Meadow Branch Cem.
Location Carroll Co., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

NOV 5 - 1945
(Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 4 1945, 11:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 26 1941, to Nov 4 1945, and that I last saw him alive on Nov 4 1945

Immediate cause of death Chronic Myocardial Degeneration — Duration 2 yrs
Due to
Due to Arterial Hypertension — 2 yrs
Other Conditions Cerebral Apoplexy — 2 yrs
(Include pregnancy within 3 months of death)
Date of operation No operation
Major findings of operation:
of autopsy: No autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Joshua H Armacost M. D.
Address 1419 Linden Ave Balto 7 Date signed Nov 7 1945

G33868

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

49a

Registered No. G33868

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd + Calvert St.
(c) Hospital or institution: Union Memorial Hosp. 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 115
(e) Length of stay in Baltimore (yrs., mos., or days) 67

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3512 Calvert.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Miriam Stromenger

3 (b) If veteran, name war NI

3 (c) Social Security Account No. No

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single.

6 (b) Name of husband or wife None.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 12th 1878

8. AGE: Years 67 | Months 7 | Days 22 | If less than one day 13 hr. 6 min.

9. Birthplace Maryland.
(Town, county, and state)

10. Usual Occupation None.

11. Industry or business

FATHER 12. Name Mr. Charles H. Stromenger.
13. Birthplace Maryland.

MOTHER 14. Maiden Name Mary M. Nelson
15. Birthplace Maryland.

16 (a) Informant Walter M. Stromenger.
(b) Address 3512 Calvert St. City

17 (a) Burial (b) Date thereof 11/7/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 9 1945 (Date rec'd by Registrar) (b) Huntington Willis Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 4, 1945, at 2:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 13 1945, to Nov. 4 1945, and that I last saw h.r alive on Nov. 4 1945

Immediate cause of death	Duration
Respiratory Failure	
Due to Carcinoma ovaries & metastases.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Crawford N. Kirkpatrick Jr. M.D.

Address Union Memorial Hosp. Date signed 11-4-45

G33869

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G33869

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5348 Reisterstown Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5348 Reisterstown Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Andrew Whitmore

3 (b) If veteran, name war	3 (c) Social Security Account No.
NONE	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Pearl Irene Whitmore
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 17, 1905

8. AGE: Years	Months	Days	If less than one day
40	0	17	hr. min.

9. Birthplace Petersburg, Va. (Town, county, and state)
10. Usual Occupation Patent Medicine Business
11. Industry or business Self

FATHER
12. Name William Ed. Whitmore
13. Birthplace Va.

MOTHER
14. Maiden Name Mary Lalia Lafoon
15. Birthplace Va.

16 (a) Informant Mrs. Pearl I. Whitmore
(b) Address 5348 Reisterstown Rd.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11/7/45 (month) (day) (year)
(c) Cemetery or crematory –
Location Petersburg, Va.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 5 - 1945 (Date rec'd by registrar) (b) Huntington Hotel Baltimore MD

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/4/45 19 at 9:51 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D. Medical Examiner.
Date signed 11/7/45

VS 151

G33870 BALTIMORE CITY HEALTH DEPARTMENT G33870
CERTIFICATE OF DEATH
Registered No. 106a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to state the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St.
(c) Hospital or institution: Bon Secours Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Catonsville Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 809 Frederick Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME David R. Humbright Jr.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	S.

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov. 26, 1944

8. AGE: Years	Months	Days	If less than one day
	11	7	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business —

FATHER
12. Name David
13. Birthplace North Carolina

MOTHER
14. Maiden Name Glady's Davis
15. Birthplace Morgan Md.

16 (a) Informant Mr. David Humbright Sr.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 5 1945 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Winsor Mill Rd.

18 (a) Funeral director L. Heckmann & Son
(b) Address 32 S. Broadway

19 (a) (Date rec'd by registrar) (b) Registrar

NOV 5 - 1945 Washington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/3 1945, at 10:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5:15 PM 11/3 1945 to 11/3 1945 and that I last saw him alive on 11/3 1945

Immediate cause of death: Respiratory collapse — Duration —
Due to Acute laryngo-tracheo bronchitis. — Duration 4 hrs 45 min
Due to —
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature F. D. Hickel Jr.
Address Bon Secours Hosp. Date signed M. 11 D. 3 1945

G33871

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 82

G33871 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 257 S. Mason Ext.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) —?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 257 So. Mason Ext. (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Sweden

3 (a) FULL NAME John Ernst Nordquist

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-03-4572

4. Sex M | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 24 1861

8. AGE: Years 54 | Months 4 | Days 9 | If less than one day hr. min.

9. Birthplace Sweden (Town, county and state)

10. Usual Occupation Cabinet Maker

11. Industry or business Cummins & Co.

FATHER
12. Name Ernst Wm.
13. Birthplace Sweden

MOTHER
14. Maiden Name Eva Johnson
15. Birthplace Sweden

16 (a) Informant Mr. Ernst Nordquist
(b) Address 257 So Mason Ext

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 6 45 (month) (day) (year)

(c) Cemetery or crematory Holy Sepulchre
Location Belair Rd

18 (a) Funeral director Heimann & Son
(b) Address 32 S. Broadway

19 (a) NOV 5 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 3. 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 12 1945, to Nov 3 1945, and that I last saw him alive on Nov 3 1945.

Immediate cause of death Myocardial Insufficiency — Duration 2 D

Due to Bulbar Poliomyelitis — Duration 3 W

Due to Arteriosclerosis, Hypertension. — Duration Many Yrs

Other Conditions Diabetes Insipidus (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jno. T. Legg M. D.
Address 15 E. Madison Date signed 11/5/45

G33872

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

G33872 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 d.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 902 N. Charles Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Larkin, Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If wife, give age — years

7. Birth date of deceased (mo., day, yr.) Mar 22, 1897

8. AGE: Years 48 | Months 7 | Days 11 | If less than one day hr. min.

9. Birthplace Balto Md (town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Govt. Selected Service

FATHER 12. Name Chas A. Larkin

13. Birthplace Md

MOTHER 14. Maiden Name Anna V. O'Brien

15. Birthplace Md

16 (a) Informant Mr. John E. Larkin

(b) Address 3 Dommerich Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 7 45 (month) (day) (year)

(c) Cemetery or crematory New Cath

Location Balto Md

18 (a) Funeral director Flynn & Hemmings

(b) Address 1426 Eutaw St

19 (a) NOV 5 - 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 3 1945, at 7:30 P.M.

21. I certify that I took charge of the remains described above, held an ~~Autopsy, Inspection or Inquiry~~ Inspection thereon and from the evidence obtained by said ~~Autopsy, Inspection or Inquiry~~, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardio-vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Benedict Skotarelis M.D. Medical Examiner.

Date signed November 4, 1945.

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G33873

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 488

Registered No. G33873

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital H
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 Mos.
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Calvert & Saratoga Sts. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Sister Mary Stanislaus Mc Kay R.S.M.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept 25, 1886
8. AGE: Years 59 Months 1 Days 9 If less than one day hr. min.
9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Religious
11. Industry or business

FATHER
12. Name Benjamin McKay
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth Combo.
15. Birthplace Maryland.

16 (a) Informant Deceased.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/7/45 (month) (day) (year)
(c) Cemetery or crematory Mt. St. Agnes Convent
Location Mt. Washington, Balto.
18 (a) Funeral director D.W. Mears & Son
(b) Address 805 N. Calvert St. Balto.
19 (a) NOV 5 (Date received by Registrar) (b) 1945 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 4 1945; at 6.5 P M
21. I certify that death occurred on the date above stated; that I attended deceased from 8/10 1945 to 10/17 1945 and that I last saw h[illegible] alive on 11/3 1945.

	Duration
Immediate cause of death: Cardiac Regurgitation Failure	2 Mos.
Due to: Intestinal Obstruction Carcinoma Pistula	2½ Mos
Due to: Post Operative adhesions	2½ Mos
Other Conditions: Carcinoma Body of Uterus (Include pregnancy within 3 months of death)	

Date of operations 8/10/45 & 10/17/45
Major findings of operation: Incurable obstruction at sigmoid colon.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Paul P. Ziegler
Address Mercy Hosp. Date signed 11/4/45 Mo. Dy.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G33874

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G33874

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2117 E PRATT ST
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Y
(e) Length of stay in Baltimore (yrs., mos., or days) 35 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2117 E. PRATT ST
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** HYMAN W. PACHINO

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of husband or wife RAZEL

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years	Months	Days	If less than one day
60			hr. min.

9. Birthplace RUSSIA (Town, county, and state)

10. Usual Occupation DAIRY STORE

11. Industry or business

FATHER
12. Name JACOB
13. Birthplace RUSSIA

MOTHER
14. Maiden Name BESSIE
15. Birthplace RUSSIA

16 (a) Informant WIFE
(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 11-5-45 (month) (day) (year)
(c) Cemetery or crematory MT. CARMEL
Location GERMAN HILL RD

18 (a) Funeral director JACK LEWIS INC
(b) Address 1439 E. BALTO. ST

19 (a) (Date rec'd by registrar) (b) [illegible] for William [illegible]

NOV 5 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-4-45 19 20, at 9 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 11 1945 to 11/4 1945, and that I last saw h[im] alive on 11/4 1945.

Immediate cause of death Coronary Thrombosis — Duration Sudden

Due to Arteriosclerosis

Due to

Other Conditions Spinal arthritis, Senathrea — 1 yr.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph D. Blum M. D.

Address 120 E Pratt Date signed 11/5/45

X

G33875

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

G33875 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital 1r
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 71 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1009 N. Castle St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME John Hilscher

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary Hilscher

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Sept 4, 1884

8. AGE: Years 71 | Months 12 | Days 29 | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Sailor

11. Industry or business

FATHER
12. Name Anton Hilscher
13. Birthplace Md.

MOTHER
14. Maiden Name Sopha Schwartz
15. Birthplace Md.

16 (a) Informant Richard Hilscher
(b) Address 1009 N. Castle st

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 11-6-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Oak 2nd

18 (a) Funeral director Francis Brockton
(b) Address 900 N Eutaw st

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 3 1945, at 8:45 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 30 1945 to Nov 3 1945 and that I last saw him alive on Nov 3 1945.

	Duration
Immediate cause of death Intracranial hemorrhage - ?	5 hrs.
Due to Trauma - fall + hit head in bathtub	
Due to	
Other Conditions Arteriosclerotic heart disease Carcinoma of lung ?	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence November 3 at 1:45 P.M
(c) Where did injury occur? Baltimore, Md.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Union Memorial Hospital While at work? no
(Specify type of place)
(e) Means of injury Fall and hit head on floor

23. Signature J. Frank [illegible] M. D.
Address Union Memorial Hospital Date signed 11-7-45

Registrar Huntington Williams by Howard J. Madden, M. D.

G33876

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G33876 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1127 Fawsons St
(c) Hospital or institution:

16

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 years.

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1127 Fawsons St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jeff Thornton

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	colored	married

6 (b) Name of husband or wife Mary Thornton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) march 14 1882

8. AGE: Years	Months	Days	If less than one day
63	7	19	hr. min.

9. Birthplace Va
(Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name Washington Thornton
13. Birthplace md

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Mary Thornton
(b) Address 1127 Fawsons St

17 (a) Buried (b) Date thereof 11-5-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn.
Location md

18 (a) Funeral director George B. Kilson
(b) Address 1303 Pennsylvania Ave

19 (a) (b)
(Date rec'd by registrar) Registrar

NOV 5 - 1945 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 2 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/11/1945 to 11/2/1945
and that I last saw him alive on 11/1/1945

Immediate cause of death	Duration
Coronary Occlusion	
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wayland E. Jones
Address 1300 N. Fremont Ave Date signed 11/5/45 D.

Wayland E. Jones

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be answered. Do not use ditto marks. Be sure to write the causes of death clearly and legibly. correct age is especially important. Physicians: please write

G33877

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45 C

G33877. Registered No.

write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3139 S. Baltimore Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 156 N. Linwood ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Haubner

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Maria Haubner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 13 1895

8. AGE: Years	Months	Days	If less than one day
50	1	18	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation Baker
11. Industry or business

FATHER
12. Name Haubner
13. Birthplace Germany

MOTHER
14. Maiden Name Marg.
15. Birthplace Germany

16 (a) Informant Maria Haubner (Wife)
(b) Address 156 N. Linwood ave

17 (a) Burial (b) Date thereof 11-5-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4200 Belair Rd.

18 (a) Funeral director Charles S. Zeiler
(b) Address 3605 Fait Ave

19 (a) NOV 5 1945 (b)
Date received by registrar Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-1- 1945, at 7-55- P.M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary disease

Due to

Other Conditions Acute Pulmonary Edema
Hypertrophy & Dilatation of Heart
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Wheeler M.D.
Medical Examiner.
Date signed 11-2-45

Hunting for Williams, M.D.

G33878

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

G33878 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5217 York Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5217 York Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret E. Murphy
3 (b) If veteran, name war
3 (c) Social Security Account No. None

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Unkn 1877

8. AGE: Years 68 | Months 4 | Days 12 | If less than one day hr. min.

9. Birthplace Balto (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Patrick Murphy
13. Birthplace Ireland

MOTHER
14. Maiden Name Essen Coleman
15. Birthplace Ireland

16 (a) Informant Edna Carozza
(b) Address 5217 York Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 6 45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd.

18 (a) Funeral director Hart & Bogel
(b) Address 7110 Belair Rd

19 (a) (Date rec'd by registrar) (b) Registrar

Huntington Hillcrest, M.D.

VS Form NOV 5 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 3 1945 at 9:55 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 5 1940 to Nov. 3 1945 and that I last saw her alive on Nov. 3 1945.

Immediate cause of death Cerebral Hemorrhage — Duration 5 YRS -

Due to Hypertensive Cardiovascular disease. — 5 YRS -

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Anthony Carozza
Address 5217 York Rd Balto Md. Date signed Nov. 7 45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G33879

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

G33879 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Joseph's Hospital 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days
(e) Length of stay in Baltimore (yrs., mos., or days) 45yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3709 Clarement Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Adolph E Krueger.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	

6 (b) Name of husband or wife Anna
6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) May 20-1870

8. AGE: Years	Months	Days	If less than one day
75	5	14	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation
11. Industry or business Butcher

FATHER
12. Name Adolph Krueger
13. Birthplace Germany

MOTHER
14. Maiden Name Dora Kruder
15. Birthplace Germany

16 (a) Informant Mary R Krueger
(b) Address 436 Drew St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 7th (month) (day) (year)
(c) Cemetery or crematory St Matthews Cem
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2006 Orleans St

19 (a) (b)
NOW ready to register
Waiting for signature

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-4 1945 at 1 05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-17 1945 to 11-4 1945 and that I last saw him alive on 11-3 1945

Immediate cause of death	Duration
Cardio-Respiratory Failure	
Due to Toxemia	
Due to Carcinoma of Liver	
Other Conditions - Hydronephrosis hydroureter.	

(Include pregnancy within 3 months of death)
Date of operation 10-23-45
Major findings of operation: - Ca of Liver
of autopsy: - Same.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence 0 at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work (Specify type of place)
(e) Means of injury
23. Signature Eugene F Riley M.D.
Address 1406 A Cathedral St Date signed 11/7/45

VS 150

G33880

481017

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

153

G33880 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1605 N. Bentalou St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marvin Ripnick.

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	SINGLE

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-1-31

8. AGE: Years	Months	Days	If less than one day
14	2	4	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation None.
11. Industry or business

FATHER 12. Name Jacob J Ripnick
13. Birthplace Md.

MOTHER 14. Maiden Name Peare Fagan
15. Birthplace Md.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-5-45 (month) (day) (year)
(c) Cemetery or crematory Druedale
Location

18 (a) Funeral director Jack Reiss Inc
(b) Address 1439 E. Balto St

19 (a) NOV 5 - 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 5 1945, at 2. A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 26 1945 to Nov. 5 1945, and that I last saw him alive on Nov. 5 1945.

Immediate cause of death disseminated lupus erythematosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John Grant Wilkins
Address Johns Hopkins Hosp Signed 11/5/45

VS 180

G33881

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √93D

Registered No. G33881

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1815 N Patterson Park Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1815 N Patterson Park Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry E. Frazier
3 (b) If veteran, name war
3 (c) Social Security Account No. 216-05-1600

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Katherine Frazier
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 26th 1883

8. AGE: Years	Months	Days	If less than one day
61 62	10	8	hr. min.

9. Birthplace Md
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Katherine Frazier
(b) Address 1815 N. Patterson Park Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 6th 1945 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Ave

18 (a) Funeral director Leo G. Brooh
(b) Address 2203 N. Patterson Park Ave

19 (a) Nov 5 - 1945 (Date filed by registrar) (b) Huntington Williams, M.D. Registrar

VS 100 Dr Weiss

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 3rd 1945, at 4.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/29/ 1945 to Nov 5, 1945 and that I last saw h~~e~~ alive on Nov. 3, 1945.

Immediate cause of death	Duration
Coronary Thrombosis	4 days
Due to Arteriosclerotic Cardio-vascular Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. Hamburger M. D.
Address 927 E. 20th Ave Date signed 11-5-45

G33882 Brady
5706 Hartford Road

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G33882

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2704 Bayonne Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2704 Bayonne Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Thomas Groton
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Jane Hotchkiss
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept. 5 1861

8. AGE: Years 84 | Months 1 | Days 29 | If less than one day hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation None
11. Industry or business

MOTHER / FATHER
12. Name Virginia Groton
13. Birthplace Balto. Md.
14. Maiden Name Ellen E Merrick
15. Birthplace Md.

16 (a) Informant Mrs Percy Braswell
(b) Address 2704 Bayonne Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/5/45 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location North Ave

18 (a) Funeral director Leonard J. Rucker
(b) Address 5306 Harford Road

19 (a) NOV 5 1945 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 3rd 1945 at 4 20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 20 1945, to Nov 3 1945, and that I last saw [illegible] alive on Nov 2nd 1945.

Immediate cause of death: Cerebral Hemorrhage — Duration 13 days
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide None
(b) Date of occurrence Report at M
(c) Where did injury occur? None
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature L. L. Goody M.D.
Address 5706 Hartford Rd Date signed 11/5/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G33883

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 164 c

Registered No. G33883

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Md.
(c) Hospital or institution Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Towson
(If outside city or town limits, write RURAL and give town)
(d) Street No. Providence Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Richard Spencer Isennock

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 219-03-2557

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary Rosanna Isennock

6 (c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): June 14, 1875

8. AGE: Years: 70 | Months: 4 | Days: 19 | If less than one day: ---hr. ---min.

9. Birthplace: Jacksonville, Balto. Co., Md.
(Town, county, and state)

10. Usual Occupation: Farmer

11. Industry or business: Retired

FATHER
12. Name: Charles Isennock
13. Birthplace: Balto. Co., Md.

MOTHER
14. Maiden Name: Frances R. Turnbaugh
15. Birthplace: Balto. Co., Md.

16 (a) Informant: Mrs. Mary R. Isennock
(b) Address: Providence, Balto. Co., Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Nov. 6, 1945 (month) (day) (year)
(c) Cemetery or crematory: Chestnut Grove Cem.
Location: Jacksonville, Balto. Co., Md.

18 (a) Funeral director: John Burns' Sons
(b) Address: Towson, Maryland

19 (a) (Date received by registrar) NOV 5 1945 (b) Burrington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 3, 19 45, at 11:20 A. M.

21. I certify that I took charge of the remains described above, held an Inspection + Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Gunshot wound of head.

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-3-45 at 6:30 P. M.
(b) Where did injury occur? Providence Rd.
(c) Did injury occur at home, on farm, industrial place, in public place? Home. While at work? No.
(d) Means of injury: Shot gun

23. Signature: Benedict Skaterlee, Medical Examiner.
Date signed: November 4, 1945.

G33884

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

G33884 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1925 W. Lexington
(c) Hospital or institution: No

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1925 W. Lexington
(If rural give location)
(e) Citizen of foreign country? Md. (Yes or No)
If yes, name country

3 (a) FULL NAME Florence Amelia Carr

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced widowed

6 (b) Name of husband or wife Chester Carr
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 7 1867

8. AGE: Years 78 | Months 5 | Days 25 28 | If less than one day hr. min.

9. Birthplace Annapolis Co. Md
(Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business —

FATHER 12. Name Wm. B. Jimmes
13. Birthplace Md. U.S.

MOTHER 14. Maiden Name Louisa Brockett
15. Birthplace Md.

16 (a) Informant Mrs. Ira Shipley
(b) Address 1925 W. Lexington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 6/45 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Olivet & Greenmount Ave.

18 (a) Funeral director John O. Mitchell & Son
(b) Address 1900 Eutaw Place

19 (a) Nov 5 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 4 1945, at 4:50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct-28 1945, to Nov. 4 1945, and that I last saw h[illegible] alive on Nov. 3 1945

Immediate cause of death	Duration
(a) Myocarditis	1940
Due to (b) Arteriosclerosis	10 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul Brown M.D.
Address 1663 W. North Ave. Date signed 11/5/45

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G33885

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G33885 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 M
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 517 E. GITTINGS ST. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME Henry C. Wentworth
3 (b) If veteran, name war
3 (c) Social Security Account No. 705-05-6128

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.
6 (b) Name of ~~husband or~~ wife NELLIE WENTWORTH
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUNE 26, 1892

8. AGE: Years 53 | Months 4 | Days 15 | If less than one day hr. min. 13

9. Birthplace BALTIMORE (Town, county, and state)
10. Usual Occupation Yard foreman
11. Industry or business B & O Railroad

FATHER
12. Name HENRY C. WENTWORTH
13. Birthplace BALTIMORE

MOTHER
14. Maiden Name MINNIE LYNCH
15. Birthplace BALTIMORE

16 (a) Informant Mrs. Nellie D. Wentworth
(b) Address 517 E. Gittings St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/7/45 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Ritchie Highway

18 (a) Funeral director McCully Funeral Home
(b) Address 130 E. Fort Ave.

19 (a) (Date received by local registrar) NOV 5 1945 (b) Registrar Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 4th 1945, at 12 50 M

21. I certify that death occurred on the date above stated; that I attended deceased from OCT. 31 1945 to NOV 4 1945 and that I last saw him alive on Nov. 4 1945.

Immediate cause of death	Duration
PULMONARY	
Due to TUBERCULOSIS	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. L. Wheeler
Address South Balto. Gen. Hosp. Date signed 11/4/45

VS 150

G33886

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G33886 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1230 W 37th St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1230 W 37th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emily J. Keith

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	widowed

6 (b) Name of husband or wife Wm. R. Keith
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct 12, 1873

8. AGE: Years	Months	Days	If less than one day
72	-	21	hr. min.

9. Birthplace Maryland.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Thomas Neal.
13. Birthplace Maryland.

MOTHER
14. Maiden Name Emily Dean.
15. Birthplace Maryland.

16 (a) Informant Mrs. Gertrude Lewis.
(b) Address 1232 W 37th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 6/45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location

18 (a) Funeral director Ehrenwerth & Donovan
(b) Address 3615-17 Chestnut Ave

19 (a) NOV 5 1945 (b) Registrar
(Date received by registrar)

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 2, 1945 at 6:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1939, to Nov 2 1945, and that I last saw her alive on Nov 2 1945.

Immediate cause of death	Duration
Cardiac decomp.	3 mo
Due to Arteriosclerotic CVD	7
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lawrence L. Shumaker M. D.
Address 3711 Falls Rd Date signed 11-3-45

VS 150

X

G33887

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 186a

Registered No. G33887

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Md.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RFD or St. and give town)
(d) Street No. 512 N. Pine St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rudolph Sheppard

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Elizabeth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25, 1905

8. AGE: Years	Months	Days	If less than one day
39 40	10	13	hr. min.

9. Birthplace Northampton Co., Va. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ?
13. Birthplace Va.

MOTHER
14. Maiden Name Drusciella Collins
15. Birthplace Va.

16 (a) Informant Eliz. Sheppard
(b) Address 512 N. Pine St

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof Nov. 5 '45 (month) (day) (year)
(c) Cemetery or crematory
Location Exmore, Virginia.

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St

19 (a) (Signature of registrar) (b) Thurlington Williams, Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 29, 1945, at 10:35 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fractured Skull.
Subdural Hematoma.
Due to Laceration of Brain.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-25-45 at 9 P. M.
(b) Where did injury occur? Waldorf, Md
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial Plant
(d) Means of injury Fell from truck - Truck not in motion

23. Signature Benedict Sherlaclis M.D. Medical Examiner.

Date signed October 29, 1945.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G33888 G33888

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

Registered No. -

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
U.S. Marine Hospital, Balto, Md. 8
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 27 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2617 Llewellyn Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Smith, Harry

3 (b) If veteran, name war: WWI

3 (c) Social Security Account No.:

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Dorothy Smith

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Dec - 31 - 1895

8. AGE: Years 49 | Months 10 | Days 4 | If less than one day: hr. min.

9. Birthplace Cincinnati, Chio
(Town, county, and state)

10. Usual Occupation sheet metal worker

11. Industry or business

FATHER
12. Name Thomas Smith
13. Birthplace Kentucky

MOTHER
14. Maiden Name Ida May Smith
15. Birthplace Indiana

16 (a) Informant Records
(b) Address US Marine Hospital, Balto, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 - 7 - 45 (month) (day) (year)
(c) Cemetery or crematory Baltimore Natl Cem
Location Frederick Road

18 (a) Funeral director John C. Miller, Inc.
(b) Address 2437 E. Oliver St

19 (a) (Date rec'd by local registrar) (b) Washington Williams, M.D. Registrar
D - 2945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 4 1945, at 2:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 25 1945, to Nov. 4 1945 and that I last saw him alive on Nov. 4 1945.

	Duration
Immediate cause of death Carcinoma of head of pancreas with metastasis to liver and ob-	?
Due to structive jaundice	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon
Address Clinical Director US Marine Hospital, Balto, Md. Date signed 11/5/45 M.D.

X

G33889

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G33889 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information must be given, or a delay will result. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4800 Homer Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4800 Homer Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARGARET A. DAHLE

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
No	None	F	W	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10, 1859

8. AGE: Years	Months	Days	If less than one day
86	4	24	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Charles F. Dahle
13. Birthplace Balto.

MOTHER
14. Maiden Name Jane McKewen
15. Birthplace Balto., Md.

16 (a) Informant Mrs. James M. Grant
(b) Address 4800 Greenmount Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/7/45 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

NOV 5 - 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 4, 1945, at 6:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1945 to Nov 4 1945 and that I last saw h[illegible] alive on Nov 4 1945

Immediate cause of death	Duration
Cerebral Hemorrhage	1 day
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Hugh D Bulbert M.D.
Address 588 Park Heights Ave Date signed 11/6/45

G33890 G33890

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No.

write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2503 Arbuton Av.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) Y
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2503 Arbuton Av. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Awalt

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife George L. Awalt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 29, 1867

8. AGE: Years	Months	Days	If less than one day
78	7	6	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Stephen Whalen
13. Birthplace Md.

MOTHER
14. Maiden Name Georgiana McNeil
15. Birthplace Md.

16 (a) Informant Mr. George S. Awalt
(b) Address 718 Hunting Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/7/45 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 5 1945 (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/5 1945, at 3:40 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardio-vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh B. McNeely M.D. (Medical Examiner)
Date signed 11/5/45

G33891

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

47D

G33891
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given. If any item is unknown, write "unknown." Be sure to give correct age in each case. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County Anne Arundel
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. FERNDALE
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME JENNIES WILDER

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-22-1783

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 6, 1875

8. AGE: Years	Months	Days	If less than one day
70	01	28	hr. min.

9. Birthplace VIRGINIA
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name NAT WILDER
13. Birthplace VIRGINIA

MOTHER
14. Maiden Name NORA HAMMOCK
15. Birthplace VIRGINIA

16 (a) Informant Frederick H. Wasmus
(b) Address Ferndale, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 6, 1945 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Brooklyn Md. R.F.D.

18 (a) Funeral director Thomas W. Douglass
(b) Address New Burnie, Md.

19 (a) NOV 5 - 1945 (Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 4 1945, at 1:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 25 1945, to Nov 4 1945, and that I last saw him alive on Nov 4 1945.

Immediate cause of death	Duration
GENERALIZED	
Due to CARCINOMATOSIS	3
Due to	over
Other Conditions LUNG ABSCESS	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] E. Wheeler M. D.
Address South Baltimore Gen. Hosp. Date signed 11/4/45

X

G33892

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

148a

G33892 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun Sts.
(c) Hospital or institution: Fr. Square Hosp't.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Anne Arundel
(c) City or town Glen Burnie, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 103 E. 4th Ave. South.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ethel L. Weese — S 35838

3 (b) If veteran, name war —

3 (c) Social Security Account No. 220-16-4488

4. Sex F | 5. Color or race White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Gerard Weese

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/21/1925

8. AGE: Years 20 | Months 1 | Days 12 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business H.W.

FATHER
12. Name Steve Kalandros
13. Birthplace Lipso - Greece

MOTHER
14. Maiden Name Virginia James
15. Birthplace Bridgeport Ohio

16 (a) Informant Mrs. Steve Kalandros
(b) Address Glen Burnie, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 6, 1945 (month) (day) (year)
(c) Cemetery or crematory Glen Haven Cem
Location Glen Burnie, Md.

18 (a) Funeral director Thomas W. Pringleton
(b) Address Glen Burnie, Md.

19 NOV 5 1945 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 3 1945, at 4:40 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-2 1945, to 11-3 1945, and that I last saw h.. alive on 11-3 1945.

Immediate cause of death: Post partum eclampsia — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Dr. consulting

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. K. Kazerian M. D.
Address Franklin Square Hosp. Date signed 11-3-45

G33893

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G33893

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Street
(c) Hospital or institution: Little Sisters of the Poor 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 yrs 1m
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Theresa Leuwenberg Hess

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Carl Hess deceased

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 18, 1869

8. AGE: Years	Months	Days	If less than one day
76 yr.	9 10	5 16	hr. min.

9. Birthplace Germany (town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Alexander Leuwenberg
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Stiek
15. Birthplace Germany

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley Street City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 6, 1945 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location A. A. Co.

18 (a) Funeral director Rita Wiedefeld
(b) Address 914 Greenmount Ave

19 (a) Nov 6 1945 (Date received by registrar) (b) Huntington Wisconsin

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 4- 1945, at 2-45P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1- 1945 to Nov 4- 1945 and that I last saw her alive on Nov 4- 1945

Immediate cause of death	Duration
Cerebral - Hemorrhage	1 day.
Due to Arterio Sclerosis	6 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Gill Hall M. D.
Address 1631 E. North Ave Date signed Nov 6-45

G33894

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 477

G33894 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 4 days
(e) Length of stay in Baltimore (yrs., mos., or days): 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County:
(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No.: 921 Gorsuch Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country:

3 (a) FULL NAME: Anthony, Frank

3 (b) If veteran, name war:

3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife: Lillian Anthony
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.): Feb. 5, 1878

8. AGE: Years	Months	Days	If less than one day
67	8	28	____ hr. ____ min.

9. Birthplace: Italy (Town, county, and state)
10. Usual Occupation: sheet metal worker
11. Industry or business:

FATHER
12. Name: Dominic Anthony
13. Birthplace: Italy

MOTHER
14. Maiden Name: ?
15. Birthplace: Italy

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 6 1945 (month) (day) (year)
(c) Cemetery or crematory: ~~Holy Redeemer~~ ~~Holy Redeemer~~
Location: [illegible] Baltimore

18 (a) Funeral director: Rita Wiedefeld
(b) Address: 914 Kremmerville Ave.

19 (a) NOV 8 1945 (Date rec'd here) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 3 1945, at 4:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 31 1945, to Nov. 3 1945 and that I last saw h im alive on Nov. 3 1945.

Immediate cause of death	Duration
Carcinoma of right lung	2 yrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy: None done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: John L. Wilson
John L. Wilson, Sr. Surgeon M.D.
Address: Clinical Director Date signed 11/5/45
US Marine Hospital, Balto, Md.

G33895 G33895

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3417 Woodstock Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3417 Woodstock Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Susan Kane

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, ~~married~~, widowed, or divorced Widow

6 (b) Name of ~~husband~~ or wife Edward M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 30 1867

8. AGE: Years 78 | Months 1 | Days 3 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name ? Halstead

13. Birthplace

MOTHER 14. Maiden Name Elizabeth Fuchs

15. Birthplace Baltimore Md

16 (a) Informant Anna M. Kane

(b) Address 3417 Woodstock Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 6/45 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Old Frederick Road

18 (a) Funeral director John G. Moran

(b) Address 3000 E Baltimore

19 (a) NOV 5 - 1945 (Date rec'd by Registrar) (b)

Waiting for Affidavit Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 3 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1945 to 11/3 1945, and that I last saw h.r alive on 11/3 1945.

Immediate cause of death Hypertension Cardio-Vascular Disease — Duration

Due to — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm Dolley M. D.

Address 57 E 3 Hoffman St Date signed 11/5/45

X

G33896 G33896

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1414 Ma Eldery St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John B. Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-23-99

8. AGE: Years	Months	Days	If less than one day
45	10	11	hr. min.

9. Birthplace Md (Town, county and state)

10. Usual Occupation Bag Factory

11. Industry or business

FATHER 12. Name James Jones

13. Birthplace Md

MOTHER 14. Maiden Name Angea ?

15. Birthplace Va

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/6/45 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary Cem

Location A. A. County Md

18 (a) Funeral director Joseph B. Cole & Co.

(b) Address 1364 N. Central Ave

19 (a) (Date received by registrar) (b) Huntington Williams

NOV 5 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 3 1945 at 10 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 23 1945 to Nov 3 1945 and that I last saw him alive on Nov 3 1945.

	Duration
Immediate cause of death: Respiratory failure	1 day
Due to: Uremia Due to Nephrosclerosis	7 days
Due to: Hypertension Due to Pyelonephritis?	? ? ?
Other Conditions: Cerebral Hemorrhage, Rt (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operations:

of autopsy: Extensive Kidneys

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature F. Brennan J. Stephens

Address Johns Hopkins Hosp. Date signed 11/4/45 M. D.

G33897

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

G33897 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2502 Alameda Blvd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., moe., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Same (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hannie O Floyd

3 (b) If veteran, name war W
3 (c) Social Security Account No. none

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 5 1869

8. AGE: Years 76 | Months 8 | Days 0 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Frisby Floyd
13. Birthplace Md

MOTHER
14. Maiden Name Mary E Phillips
15. Birthplace Baltimore Md

16 (a) Informant James Wilmer
(b) Address 2802 Alameda Blvd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/8/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Greenmount
Location Balto. Md

18 (a) Funeral director Pickhoms & Co
(b) Address 1217 E Fayette St

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

NOV 9 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 5th 1945, at 2 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 25 1945 to Nov 5 1945 and that I last saw h[illegible] alive on Nov 4 1945.

Immediate cause of death	Duration
Coronary disease	10 Days
Due to Nephritis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 1900 Harford Ave Date signed Nov 5 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be answered, or "unknown" or "none" should be written. Be sure to state the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

G33898

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G33898

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2408 Kentucky Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2408 Kentucky Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (Harry) Henry Clay Hopkins

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 217-07-9084

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	M.

6 (b) Name of husband or wife Rowena A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 5- 1874

8. AGE: Years	Months	Days	If less than one day
71	6	28	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Marine Engineer
11. Industry or business Curtis Bay Towing Co.

FATHER
12. Name O. Richard Hopkins
13. Birthplace Md.

MOTHER
14. Maiden Name Mollie B. Long
15. Birthplace Md.

16 (a) Informant Mrs Harvey H. Shriner
(b) Address 2408 Kentucky Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/6/45 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Parkville, Balto. Co.

18 (a) Funeral director Wm Cook Inc
(b) Address 217 E Saratoga St.

19 (a) (Date rec'd by registrar) (b) Huntington Hill Registrar

NOV 8 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 3 1945 at 4 50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-29-45 to 11-3-45 and that I last saw h[illegible] alive on 11-3-45

Immediate cause of death	Duration
Coronary Occlusion	2 days
Due to Coronary	
Due to Sclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Fred Purdy M.D.
Address 100 W Mulberry St Balto 1 Md. Date signed 11-5-45

AB-15828 G33899

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. G33899

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 yrs-6mos-13days
(e) Length of stay in Baltimore (yrs., mos., or days) 16yrs-9mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 12 Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. None (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Peter Hudson

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 29-1863

8. AGE: Years	Months	Days	If less than one day
82	7	5	hr. min.

9. Birthplace Sweden (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Hans Hudson
13. Birthplace Sweden

MOTHER
14. Maiden Name ?
15. Birthplace Sweden

16 (a) Informant: Baltimore City HOspitals(Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 6-45 (month) (day) (year)
(c) Cemetery or crematory Dulaney Valley Road
Location Frederick Road

18 (a) Funeral director William Roth Inc
(b) Address 1029 St. Paul Street

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 4- 1945, at 3.25PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-11 1928, to 11-4 1945, and that I last saw him alive on 11-4- 1945

Immediate cause of death: Cerebral Hemorrhage
Due to: Lobar Pneumonia, right
Due to: Hypertension
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation: none
of autopsy: Lobar Pneumonia, rt.

Duration: 7

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature I. P. Jernigan
Address Baltimore City Hosp. Date signed 11-5-45 M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

H 33900

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

G33900 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be entered. Use a typewriter if convenient. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 Days
49-3 & 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 105 East 33rd Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Hof

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Harry Hof (d)
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 22, 1896

8. AGE: Years	Months	Days	If less than one day
49	3	12	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Michael Kelly
13. Birthplace Maryland

MOTHER
14. Maiden Name Margaret Connelly (d)
15. Birthplace Maryland

16 (a) Informant Balto. City Hospitals Records
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof 11/7/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Cathedral
Location Balto., Md.

18 (a) Funeral director Tallhorn & Son
(b) Address 1141 N. Paul St.

19 (a) NOV 5 - 1945 (b) Huntington Williams Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 4 1945 at 1:30A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 15 1945, to Nov. 4, 1945, and that I last saw her alive on Nov. 4, 1945.

Immediate cause of death	Duration
Uraemia	
Due to Ca of Cervix + chronic hemorrhaging	
Due to frozen pelvis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: Biopsy - Ca of Cervix
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Eugene A Patterson M. D.
Address B.C.H. Date signed 11-4-45

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G33901 — BALTIMORE CITY HEALTH DEPARTMENT — G33901

CERTIFICATE OF DEATH

Registered No. 835

Polavoy

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Green Spring & Belvedere Ave
(c) Hospital or institution: LEVINDALE
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3516 White Chapel Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ludwig Polavoy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Jacob

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years 75 | Months | Days | If less than one day hr. min.

9. Birthplace Novgorod Russia
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Abraham —
13. Birthplace Russia

MOTHER
14. Maiden Name —
15. Birthplace Russia

16 (a) Informant Mrs Polavoy
(b) Address 3832 Cottage Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-6-45 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge
Location

18 (a) Funeral director Jack Levin Inc
(b) Address 1739 E. Baltimore St

19 (a) Registered NOV 7 1945 Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH November 5 1945, at 6 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-20 1943, to 11-5 1945, and that I last saw h alive on 11-5 1945.

Immediate cause of death	Duration
Cerebral Hemiplegia	
arteriosclerosis,	
Due to	
Due to	
Other Conditions	
(Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H Edmund Levin M. D.
Address Levindale Date signed

VS .150

X

G33902 M. Burrell

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G33902

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) 11 days.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1421 St. Matthews St.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

G 35468

3 (a) FULL NAME Alexander Butler

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10 16 43 10-27-45

8. AGE: Years | Months | Days: 11 | If less than one day: hr. min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name William Andrew Butler
13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Ernestine Howard
15. Birthplace Balto. Md

16 (a) Informant Ernestine Butler
(b) Address 1421 St. Matthews St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School NOV 5 1945

18 (a) Funeral director Commissioner of Health
(b) Address

NOV 6 1945 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-27-1945; at 7 20 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-22-1945, to 10-27-1945, and that I last saw him alive on 10-27-1945.

Immediate cause of death	Duration
Due to yr. malignancy	2 mos.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature O. E. Bennewell M. D.
Address 121 Cinquefoil Date signed 11-6-45

VS 150

3060

G33903

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G33903 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be entered. If the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1613 W. Mulberry
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 1 da

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1613 W. Mulberry St (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country —

3 (a) FULL NAME Baby Richardson

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 4, 1945

8. AGE: Years | Months | Days | If less than one day 4 hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER
12. Name Lyvin Richardson
13. Birthplace Wayne Co, N.C

MOTHER
14. Maiden Name Pauline Richardson
15. Birthplace Wayne Co, N.C

16 (a) Informant Pauline Richardson
(b) Address 1613 W. Mulberry St

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School NOV 5 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 NOV 6 1945 (Date rec'd by registrar) Municipal Hospitals Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 5 19 45, at 12 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 4 19 45 to Nov. 5 19 45, and that I last saw h[illegible] alive on Nov. 5 19 45.

Immediate cause of death Premature Birth — Duration

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. W. Reckling Jr M.D.
Address 426 N. Johnson St Date signed 11/6/45

3061

G33904 ✓ G33904

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a Registered No.

write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) d. o. a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 410 S. Patrick Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Herman Schaefer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Hattie Schaefer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10 / 26 / 1898

8. AGE: Years 47 | Months — | Days 8 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Plumber

11. Industry or business

FATHER 12. Name Samuel Schaefer
13. Birthplace Maryland

MOTHER 14. Maiden Name Faulk
15. Birthplace Maryland

16 (a) Informant Hattie Schaefer
(b) Address 410 S. Patrick St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-7-45 (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location Baltimore Md

18 (a) Funeral director F. B. Kirkpatrick Son
(b) Address 300 Eutaw Place, Baltimore, Md.

19 (a) (Date rec'd by) Nov 5 1945 (b) Hunting for Registrar

V6351

MEDICAL CERTIFICATION

20. DATE OF DEATH November 3 1945, at P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:
(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Stutarelis M.D.
Medical Examiner.
Date signed November 4, 1945.

X

G33905

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G33905

Registered No.

CERTIFICATE OF DEATH 45a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 59 days
(e) Length of stay in Baltimore (yrs., mos., or days) 59 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa (b) County
(c) City or town Wellsville (If outside city or town limits, write RURAL and give town)
(d) Street No. Route #1 Pa (If rural give location)
(e) Citizen of foreign country? (Yes or No) No
If yes, name country

3 (a) FULL NAME Georg Weaver

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) [illegible] 1873

8. AGE: Years	Months	Days	If less than one day
72			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 14/45 (month) (day) (year)
(c) Cemetery or crematory Wellsville Prank Cem
Location Wellsville Pa

18 (a) Funeral director ODER Funeral Home Inc
(b) Address 464 Jackson

19 (a) (Date received by registrar) (b) Registrar

NOV 6 - 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-4 1945, at 12:05 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-6 1945 to 11-4 1945 and that I last saw h[illegible] alive on 11-4 1945

Immediate cause of death Respiratory failure — Duration

Due to Squamous cell carcinoma of tongue

Due to lip

Other Conditions Probable pneumonia

(Include pregnancy within 3 months of death)

Date of operation 9-19; 10-6; 10-30

Major findings of operation: Squamous cell Ca Repair

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. Dorsey Clark M. D.

Address University Hosp Date signed 11-4-45

X

JL - 97064 C33906

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

C33906 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 17 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 597 Baker St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cephas Jackson

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 19, 1915

8. AGE: Years	Months	Days	If less than one day
32	0	14	hr. min.

9. Birthplace Va.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Warren Jackson
13. Birthplace Va.

MOTHER
14. Maiden Name Emma Faunteroy
15. Birthplace Va.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 11/7/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md
18 (a) Funeral director Hez. U. Kelso
(b) Address 1303 Presstman St
19 (a) Filed Nov 6 1945 (b)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 3, 1945, at 9.20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 2 1945, to Nov. 3 1945, and that I last saw h in alive on Nov. 3 1945

Immediate cause of death: Pulmonary Tuberculosis — Duration 2

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert B. Copeland Jr. M.D.
Address Balt. City Hosp. Date signed 11/5/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item or information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

Huntington Williams, M.D.

G33907 ✓ G33907

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2807 Westfield Ave
(c) Hospital or institution: —

(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2807 Westfield Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Harmon Gohlinghorst Sr.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M

5. Color or race W.

6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Cty

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept 1. 1856

8. AGE: Years 89 Months 2 Days 3 If less than one day — hr. — min.

9. Birthplace Balto Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Geo H. Gohlinghorst

13. Birthplace

MOTHER 14. Maiden Name Unknown

15. Birthplace

16 (a) Informant Mr John Gohlinghorst

(b) Address 2807 Westfield Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 6, 45 (month) (day) (year)

(c) Cemetery or crematory Loudon Pk.

Location Edmondson Ave.

18 (a) Funeral director L. Hergmann & Son

(b) Address 32 S Broadway

19 (a) Filed by registrar Huntington Williams M.R. (b) NOV 6 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 3 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 3 1945 to Nov 3 1945 and that I last saw him alive on Nov. 2 1945.

Immediate cause of death Arteriosclerosis, Generalized, Senile. — Duration 20yrs. (progressive)

Due to —

Due to —

Other Conditions Generalized Senile changes. (progressive) 20 yrs.
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: —

of autopsy none.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward J. F. Mohr M. D.

Address 7329 Harford Rd. Date signed Nov 6, 45

X

G33908

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G33908 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 857 S. Dallas St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 857 S. Dallas St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM LOUIS Ostendorf

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 215-07-0006

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife: Theresa Ostendorf
6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) July 1, 1874

8. AGE: Years	Months	Days	If less than one day
71	4	3	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation carpenter
11. Industry or business

FATHER
12. Name Clemens Ostendorf
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Pount
15. Birthplace Germany

16 (a) Informant Mrs. Theresa Ostendorf
(b) Address 857 S. Dallas Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-6-45 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC
(b) Address NORTH AVE. & BROADWAY

19 (a) (Date rec'd by registrar) NOV 6 1945 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/3 1945, at 8.45 P M

21. I certify that I took charge of the remains described above, held an Enquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic
Cardio vascular disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh B. McNalley Medical Examiner.
Date signed 11/3/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G33909

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a ✓

Registered No. G33909

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2863 Woodbrook Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2863 Woodbrook Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY E. SUTER

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife George M. Suter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 20, 1879

8. AGE: Years	Months	Days	If less than one day
66	2	14	hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Ephriam Mallonee
13. Birthplace Balto. Co., Md.

MOTHER
14. Maiden Name Mary Ambrose
15. Birthplace Balto. Co., Md.

16 (a) Informant Mr. George M. Suter
(b) Address 2863 Woodbrook Ave.

17 (a) Burial (b) Date thereof 11/7/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 NOV 6 - 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 4, 1945, at 8:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 31 1945 to Nov 4 1945, and that I last saw h[illegible] alive on Nov 4th 1945.

Immediate cause of death	Duration yr. days
Coronary Thrombosis	
Due to Arterial Sclerosis.	5 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation No
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence — at — M
(c) Where did injury occur? No
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —
23. Signature Herbert E. Zapp M. D.
Address 3048 W. North Ave. Date signed 11/5/45

VS 180

G33910
482213

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

Registered No. G33910

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 34th & Charles Sts.
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Fred Wright

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	-

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Charlotte M. Wright
6 (c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) 11-30-65

8. AGE: Years	Months	Days	If less than one day
79	11	5	..... hr. ..... min.

9. Birthplace Boston, Mass.
(Town, county, and state)
10. Usual Occupation Dist. Salesman Manager
11. Industry or business Spencer Turbine Co.

FATHER
12. Name Waterman W. Wright
13. Birthplace Rygate Vermont

MOTHER
14. Maiden Name Bratton Whittlaw
15. Birthplace Rygate Vermont

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Cremation (b) Date thereof 11/6/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 6 - 1945 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 5 1945 at 7:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 16 1945 to Nov 5 1945 and that I last saw him alive on Nov. 5 1945

Immediate cause of death Heart Failure + Popliteal Embolus: — Duration 4 wks

Due to Arteriosclerotic Heart Disease and Hypertensive Cardiovascular Disease — Duration ± 10 yrs

Due to .....

Other Conditions Previous Pulmonary Embolus

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? .....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature Raymond Packard M.D.
Address Johns Hopkins Hosp. Date signed 11/6/45

VS 150

G33911

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

122 B

Registered No. G33911

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1905 W. Lanvale St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 d
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1905 W. Lanvale St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosa Boone.

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none.

4. Sex: female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Edward D. Boone.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Oct. 16-1870

8. AGE: Years: 75 | Months: 0 | Days: 19 | If less than one day: hr. min.

9. Birthplace: Baltimore - Md.
(Town, county, and state)

10. Usual Occupation: House wife -

11. Industry or business: - At home.

FATHER
12. Name: Harison Thompson.
13. Birthplace: Md.

MOTHER
14. Maiden Name: Mary Long.
15. Birthplace: Martinsburg - W. Va.

16 (a) Informant: Mrs. Edward D. Boone.
(b) Address: 1905 W. Lanvale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Nov. 7-'45 (month) (day) (year)
(c) Cemetery or crematory: London Park Cem.
Location: Baltimore Md.

18 (a) Funeral director: Charles J. Schwab.
(b) Address: 505 N. Monroe St.

19 (a) Date received: Nov 6 1945 (b) Registrar: Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 4. 1945 at 7.25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 28 1945 to Nov 4 1945; and that I last saw h. alive on Nov 4 1945

Immediate cause of death: Cardiac Arthritis -

Due to: Myocardial Weakness Interstat Sclerosis.

Due to: Partial Intitbal Diabetes.

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: E. Wilson M. D.

Address: 1202 St Paul St Date signed: Nov 5 '45

X

G33912

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G33912

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1708 Eutaw Place

(c) Hospital or institution Bloomingdale Nursing Home

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 90 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City, or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1309 Ensor St (If rural give location)

(e) Citizen of foreign country? Yes (Yes or No)

If yes, name country

3 (a) FULL NAME John E. Kelly

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Margaret Kelly

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 14, 1865

8. AGE: Years 80 | Months 4 3 | Days 21 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Retired Police

11. Industry or business Balto. Police Dept.

FATHER 12. Name Owen Kelly

13. Birthplace Ireland

MOTHER 14. Maiden Name Not Known

15. Birthplace Ireland

16 (a) Informant William Sh. Kelly

(b) Address 941 N. Patterson Park Ave

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 11-9-45 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Baltimore Md

18 (a) Funeral director Francis Brachbay

(b) Address 848 Chester St

NOV 6 - 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 4 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 26 1945, to Nov 4 1945, and that I last saw h. l. M alive on Nov. 3 1945

Immediate cause of death Arteriosclerotic Cardio vascular disease

Duration ?

Due to

Due to

Other Conditions Chronic nephritis uremia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Joseph S. Blum M. D.

Address 1206 E. Preston Date signed 11/5/45

G33913

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G33913 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: John Hopkins Hospital 9

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1519 N. Milton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Matilda Welch

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	MARRIED

6 (b) Name of husband or wife DALLAS J WELCH
6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) DEC 1 1884

8. AGE: Years	Months	Days	If less than one day
60	11	5	..... hr. ..... min.

9. Birthplace WESTMINSTER MD
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name JOHN HORSTE
13. Birthplace BALTIMORE MD

MOTHER 14. Maiden Name MARGARET SCHAFFER
15. Birthplace GERMANY

16 (a) Informant DALLAS J WELCH
(b) Address 1519 N MILTON AVE

17 (a) BURIAL (b) Date thereof 11-9-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory BALTIMORE CEM
Location NORTH AVE

18 (a) Funeral director J C MILLER INC
(b) Address 2433 E OLIVER ST

19 NOV 6 - 1945 Huntington Williams MD
(Date received by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/6 1945, at 5-30 A M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to h[illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Hypertensive & Arteriosclerotic C.V. Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 11/6/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G33914

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95 B

G33914 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison + Linden
(c) Hospital or institution:
Maryland General V0
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 23
(If outside city or town limits, write RURAL and give town)
(d) Street No. 138 W. Pleasant St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Frederick Bees Sr.

3 (b) If veteran, name war No | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife Elizabeth F. Bees
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1-1873

8. AGE: Years 73 | Months 7 | Days 5 | If less than one day ___ hr. ___ min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Retired Carpenter

11. Industry or business B & O. R.R.

FATHER 12. Name Frederick Bees
13. Birthplace Prussia

MOTHER 14. Maiden Name
15. Birthplace

16 (a) Informant Mrs Rose Fisher
(b) Address 2569 W. Fairmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-8-1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Putnam Post
(b) Address 2224 N. Eutaw St.

19 (a) NOV 6 - 1945 (b) (Date rec'd by registrar) Thomas Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/6 1945, at 12:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/9 1945, to 11/6 1945, and that I last saw h. alive on 11/5 1945.

Immediate cause of death	Duration
Pulmonary Edema	1 mo.
Due to Rheumatic Heart Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Martin E. Straus M. D.
Address Md. Gen'l. Hospital Date signed 11/6/45

X

G33915

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G33915

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd. & Calvert Sts.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Towson 4
(If outside city or town limits, write RURAL and give town)
(d) Street No. Hampton Lane
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Rudolph John Motz

3 (b) If veteran, name war

3 (c) Social Security Account No. 245-13-1486

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 31, 1884

8. AGE: Years	Months	Days	If less than one day
61	8	5	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Manager Car Rental Co.

11. Industry or business

FATHER 12. Name Rudolph H. Motz
13. Birthplace Germany

MOTHER 14. Maiden Name Emilie Halbach
15. Birthplace Baltimore, Md

16 (a) Informant John H. Motz
(b) Address Hampton Lane Towson

17 (a) Burial (b) Date thereof Nov 8 1945
(Burial, cremation, or removal) (month), (day) (year)

(c) Cemetery or crematory Druid Ridge
Location Pikesville Md.

18 (a) Funeral director Pennington Bros.
(b) Address 332 N. Charles St.

19 (a) (b) Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 5 1945; at 5:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 26 1945 to Nov. 5 1945 and that I last saw him alive on Nov. 4 1945

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Hypertensive Cardio-vasc. disease	
Due to	
Other Conditions Transurethral Resection Nov. 1, '45 (Include pregnancy within 3 months of death)	

Date of operation Nov. 1, '45

Major findings of operation: Enlarged Prostate.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Fred Hawkins, Jr. M.D.
Address Union Memorial Hosp. Date signed 11/5/45

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

633916

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

633916 Registered No. 3698

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 413 Robert St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) No
(e) Length of stay in Baltimore (yrs., mos., or days) Unknown

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 413 Robert St (If rural-give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Rosa Gray
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex female
5. Color or race colored
6 (a) Single, married, widowed, or divorced married
6 (b) Name of husband or wife Unknown
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1888
8. AGE: Years 57 Months Days If less than one day hr. min.
9. Birthplace Calvert Co. Md (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business Own home
FATHER 12. Name Unknown
13. Birthplace Unknown
MOTHER 14. Maiden Name Unknown
15. Birthplace Unknown
16 (a) Informant
(b) Address
17 (a) (Burial, cremation, or removal) (b) Date thereof 11-6-45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cemetery
Location Baltimore Maryland
18 (a) Funeral director Archibald A. Gaddis
(b) Address McCulloh St.
NOV 6 1945
19 (a) (Date rec'd by registrar) (b) Hunter Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-4 1945, at 7 A M
21. I certify that death occurred on the date above stated; that I attended deceased from 10-27-1945, to 11-4-1945, and that I last saw h[illegible] alive on 11-2-1945.

Immediate cause of death Myocarditis

Due to Arteriosclerosis

Due to

Other Conditions Hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
Unknown
Unknown
Unknown

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Frank A. Saunders M. D.
Address 1029 N. Stricker Date signed 11-5-45

VS 150

G33917

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G33917

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital Hospita
(c) Hospital or institution: Monument & Rutland Ave 1569
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3103 Wolcott Ave (If rural give location) a
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Moses Blum

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Late Fannie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years	Months	Days	If less than one day
68			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation
11. Industry or business Merchant

FATHER
12. Name Samuel David Blum
13. Birthplace Russia

MOTHER
14. Maiden Name Unkown
15. Birthplace Russia

16 (a) Informant Samuel D. Blum
(b) Address 3103 Wolcott Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov, 7, 1945 (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cem
Location Hamilton Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

NOV 6 - 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 5 1945 at 9:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 4 1945 to Nov 5 1945, and that I last saw h[illegible] alive on Nov 5 1945.

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Cerebrovascular accident and pneumonia	
Due to Hypertensive cardiovascular disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Norman Rudo M. D.
Address Sinai Hosp Date signed Nov 5/45

X

VS 150

G33918 BALTIMORE CITY HEALTH DEPARTMENT G33918

CERTIFICATE OF DEATH 83a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1626 N. Charles St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23
(e) Length of stay in Baltimore (yrs., mos., or days) 70yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1626 N Charles St
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Augusta M. Streeter

3 (b) If veteran, name war No | 3 (c) Social Security Account No. No

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife John Streeter | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 28, 1859

8. AGE: Years 86 | Months 9/0 | Days 6 7 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER 12. Name Feigman
13. Birthplace Germany

MOTHER 14. Maiden Name Dandkin
15. Birthplace Germany

16 (a) Informant Mrs Amelia Boucher
(b) Address Boulevard PK Pasadena Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 7 1945 (month) (day) (year)

(c) Cemetery or crematory Dulaney Hill
Location A. G. Cy

18 (a) Funeral director C. Howard Evans
(b) Address 1400 N. Charles St.

19 (a) NOV 6 - 1945 (Date filed by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 4 1945, at 1120a M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1 1945 to 11-4 1945, and that I last saw h[illegible] alive on 11-3 1945

Immediate cause of death: Cerebral Hemorrhage — Duration 2 wks.
Due to: Arteriosclerosis — 2yrs+
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. S. Bullock M. D.
Address 707 Fort Ave. Date signed 11-5-45

Huntington Williams, Inc.

X

G33919

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51B

G33919 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway + Fairmount Ave
(c) Hospital or institution:
Church Home and Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 54 days
(e) Length of stay in Baltimore (yrs., mos., or days) 45 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 115 W. Ostend Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Clinton D. Buckmaster

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/15/77

8. AGE: Years 68 | Months 7 | Days 20 | If less than one day hr. min.

9. Birthplace Maryland — (Calvert Co.)
(Town, county, and state)

10. Usual Occupation Retired Insurance Agent

11. Industry or business Life Insurance

FATHER
12. Name Gilbert Lafayette Buckmaster
13. Birthplace Calvert Co, Maryland USA

MOTHER
14. Maiden Name Martha Ann Walton - Thomas
15. Birthplace Calvert Co, Maryland

16 (a) Informant Mrs. Ebbie M. Woods
(b) Address 115 W. Ostend St. Balto 30, Md. (State)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 9, 1945 (month) (day) (year)

(c) Cemetery or crematory Parkwood Cem.
Location Baltimore Co, Md.

18 (a) Funeral director Howard Evans Balto.
(b) Address 1400 N. Charles St. Balto

NOV 6 - 1945 (Date rec'd by local Registrar) (b) Huntington Hillsboro, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 5 1945, at 6:00 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 10 1945 to Nov 5 1945, and that I last saw him alive on Nov. 5 1945.

	Duration
Immediate cause of death Coronary Thrombosis	
Due to Arteriosclerotic Heart Disease	
Due to	
Other Conditions Adenocarcinoma of Prostate; Diabetic gangrene of [illegible]	

(Important conditions within 3 months of death)

Date of operation 10/1/45

Major findings of operation: Adenocarcinoma of Prostate

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Phyllis D. Ingram M.D.
Address Lincoln Bldg Date signed 11/5/45
Phyllis D. Ingram

633920

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

633920 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 813 Madison ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 813 Madison ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth C. FREEMAN

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	widowed

6 (b) Name of husband or wife Samuel B. Freeman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 4 1878

8. AGE: Years	Months	Days	If less than one day
67	8	1	hr. min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name John Kirwin
13. Birthplace Ireland

MOTHER
14. Maiden Name Kate McGraw
15. Birthplace Ireland

16 (a) Informant Chas. L. Freeman
(b) Address 813 Madison ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 9 1945 (month) (day) (year)
(c) Cemetery or crematory Mar Cathedral
Location Balto Md

18 (a) Funeral director Henry W. Jenkins Sons Co
(b) Address McCulloh & Oakland Sts

NOV 6 - 1945

19 (a) (Date rec'd by registrar) (b) Registrar
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 5 1945 at 3:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 2 1945 to Nov. 5 1945 and that I last saw him alive on Nov. 4 1945

Immediate cause of death Pneumonia Lobar R Lower Lobe — Duration 2 days
Due to —
Due to Hemiplegia Left Side — 4 days
Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —
23. Signature Wm. P. Johnson M.D.
Address 403 Med Arts Bldg Date signed Nov. 6 1945

G33921

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G33921

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1236 Etting Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1238 Etting Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY R. CLARK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widow

6 (b) Name of husband or wife Wm. Clark
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 9, 1875

8. AGE: Years	Months	Days	If less than one day
70	7	25	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Charles Matthews
13. Birthplace Md.

MOTHER
14. Maiden Name Isabella Crowner
15. Birthplace Md.

16 (a) Informant M's Viola White
(b) Address 1016 N. Calhoun St.

17 (a) Burial (b) Date thereof 11-7-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemaley
(b) Address 578 W. Biddle St.

19 (a) NOV 6 1945 (b)
Date rec'd by (Registrar) Registrar

Huntington Williams, M.D.

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH November 3, 1945, at 5P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 15 1945, to Nov. 3. 1945, and that I last saw h[illegible] alive on Nov 3 1945.

Immediate cause of death	Duration
acute coronary occlusion	20 minutes
Due to hypertensive cardio-vascular disease	6 mos.
Due to	
Other Conditions none	

(Include pregnancy within 3 months of death)

Date of operation none
Major findings of operation:
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James D. Carr M. D.
Address 515 Marlboro St Date signed 11-5-45

G33922 BALTIMORE CITY HEALTH DEPARTMENT G33922
CERTIFICATE OF DEATH 107 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 312 N Gilmor
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days) 13 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 312 N Gilmor
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ella Louise Douglas

3 (b) If veteran, name war

3 (c) Social Security Account No.

Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: —

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/27/44

8. AGE: Years 1 | Months 13/31 | Days 6 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name Lee Douglas
13. Birthplace Maryland

MOTHER 14. Maiden Name Mary C Brooks
15. Birthplace Frederick Md

16 (a) Informant Mary C Douglas
(b) Address 312 N Gilmor

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 6, '45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) (Date rec'd by registrar) (b) Registrar
NOV 6 - 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 3 1945 at 3A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 2 1945 to Nov 3 1945 and that I last saw her alive on Nov 3 1945.

Immediate cause of death Bronchopneumonia — Duration 1 week

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William H Watts, M.D.
Address 525 N Gilmor Date signed 11/6/45

X

G33923

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

G33923 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3728 Elm Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3728 Elm Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** RANDOLPH PATRICK LOFTUS (Loftus)

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-10-0058

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife. Agnes G

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 16-1888

8. AGE: Years 57 | Months 1 | Days 18 | If less than one day ___ hr. ___ min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business Glenn L Martin

FATHER 12. Name John Loftus

FATHER 13. Birthplace Ireland

MOTHER 14. Maiden Name

MOTHER 15. Birthplace Ireland

16 (a) Informant Mrs Agnes G Loftus

(b) Address 3728 Elm Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 7 1945 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge Cemetery

Location Baltimore Md.

18 (a) Funeral director Franklin W. Leitz

(b) Address 814 W. 36 St.

19 (a) 1945 (Date rec'd by registrar) (b) Signature for Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/4/45 19___, at 2:15 P M

21. I certify that I took charge of the remains described above, held an Inspection Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury ___ at ___ M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature John R Davis, M.D. Medical Examiner.

Date signed 11/9/45

X

G33924 — BALTIMORE CITY HEALTH DEPARTMENT — G33924 Registered No.

CERTIFICATE OF DEATH 92E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5006 Ivanhoe Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Y
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5006 Ivanhoe Ave
(If rural give location)
(e) Citizen of foreign country? Unknown (Yes or No)
If yes, name country

3 (a) FULL NAME Lawrence Miller

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widow

6 (b) Name of husband or wife Catherine E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 25 1862

8. AGE: Years	Months	Days	If less than one day
83	1	9	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation
11. Industry or business Salesman Retired

FATHER
12. Name Lawrence Miller
13. Birthplace Germany

MOTHER
14. Maiden Name
15. Birthplace Germany

16 (a) Informant C. L. Miller
(b) Address 310 E Gittings Ave

17 (a) Burial (b) Date thereof 11/6/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkewood
Location Taylor Ave

18 (a) Funeral director John G. Moran
(b) Address 3000 E Baltimore St

19 (a) 6 Nov 1945 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 4th 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1941 to Nov 4 1945, and that I last saw h[illegible] alive on Nov 4 1945.

Immediate cause of death Coronary Thrombosis
Due to Senility
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration: 4 yrs.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert M. Frantz
Address 2624 St. Paul St. Date signed Nov 7 1945

X

G33925

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G33925

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1933 Penna ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1933 Penna ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louise Stanley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife John Stanley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 12, 1886

8. AGE: Years 60 | Months 2 | Days 22 | If less than one day hr. min.

9. Birthplace Dorchester Co. Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Jones
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah Hankett
15. Birthplace Md.

16 (a) Informant Sarah Pinder
(b) Address 1933 Penna ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-7-45 (month) (day) (year)

(c) Cemetery or crematory
Location Back Town, Md.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantley ave.

19 (a) (b) (Filed by registrar) Registrar
11-6-1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 4 1945, at 9:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1945 to Nov 4 1945, and that I last saw h[illegible] alive on Nov 4 1945

	Duration
Immediate cause of death Myocardial degeneration	Oct 1 to Nov 4
Due to Senility	
Due to Generalized arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Roy H Pritchett
Address 1672 David Kitlan Date signed 11-6-45 M. D.

VS 150

X

HEP #9592 G33926

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G33926 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 & 26
(e) Length of stay in Baltimore (yrs., mos., or days) 72 y 7 m 27 d

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 504 S. Macon St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Frederick (Miller) Heimiller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Bertha [illegible] (d)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 15 1872

8. AGE: Years 73 | Months 7 | Days 20 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Henry Heimiller
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth Most (d)
15. Birthplace Maryland

16 (a) Informant Balto. City Hospitals Records
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-7-45 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore

18 (a) Funeral director Leonard J. Lugk
(b) Address 6305 Harford Rd

19 (c) 1945 (Registrar's signature) Hunting & Williams Mort

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 5, 1945 at 10:35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 7, 1945 to Nov. 5, 1945, and that I last saw h im alive on Nov. 5, 1945

Immediate cause of death: Cardiac failure — Duration

Due to: Arteriosclerotic Heart Disease

Due to:

Other Conditions: Terminal Pneumonia Polyuretic Fever
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation: None

of autopsy: Arteriosclerotic Heart Disease

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature T. P. Jernigan M. D.
Address Baltimore City Hosp. Date signed 11-5-45

VS 150

X

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

G33927

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G33927 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 914 N Payson
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 914 N Payson St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Thomas Cassell

3 (b) If veteran, name war
3 (c) Social Security Account No. 219-16-7962

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Virginia
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 25 1870

8. AGE: Years	Months	Days	If less than one day
74	11	6	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Mechanic
11. Industry or business Lipsitz Scott Co

FATHER
12. Name Christian Cassell
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Unknown
15. Birthplace Baltimore Md

16 (a) Informant Mrs Virginia Cassell
(b) Address 914 N Payson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-7-45 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Baltimore Md

18 (a) Funeral director Wilhelm Bros Inc
(b) Address 1219 Eutaw St

NOV 6 - 1945 (Date rec'd by registrar)

(a) (b) Huntington Williams Funeral Home

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 6 1945, at 12:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 26 '45 to June 29 '45 and that I last saw deceased alive on June 29 1945.

Immediate cause of death

1 Hypertensive Cardio Vascular Disease

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis T. Lavy
Address 844 W. Lanvale St Date signed 11/6/45

for H.H.B. the 2 Nally, by Howard J. Malecki, M.D.

G33928

AB-97076

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V46E

Registered No. G33928

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1day
(e) Length of stay in Baltimore (yrs., mos., or days) 1day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 26 East 20th 1/2 Street
(If rural) give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Armfield Gibson

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Allie or Ora Gibson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 3- 1882

8. AGE: Years	Months	Days	If less than one day
63	6	0	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Rafield Gibson
13. Birthplace Md.

MOTHER
14. Maiden Name Louisa ?
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals (Record)
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 10-7-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Balto Co

18 (a) Funeral director Rayner Sanders
(b) Address [illegible] E Preston St

NOV 6 - 1945
(Date rec'd by registrar)

(b) Certificate for Williams filed

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 3 1945, at 12.05A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-2 1945, to 11-3 1945 and that I last saw h im alive on 11-3- 1945

Immediate cause of death	Duration
Aorta Potentia + uremia	4days
Due to	
Due to	
Other Conditions Cardiac decompensation (Include pregnancy within 3 months of death)	3 Mo.

Date of operation
Major findings of operation: Pyonephrosis + pyelonephritis Kidney - angulated
of autopsy: at post mortem

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Eugene A Patonillet
Address B-C H Date signed 11-5-45 M.D.

VS 150 TO BE APPROVED BY THE MEDICAL EXAMINER Howard S. Mueller, M.D.

G33929

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

G33929
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 No. Caroline St.
(c) Hospital or institution: Mercy Joseph Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3907 Juniper Road (If rural give location)
(e) Citizen of foreign country? U.S. (Yes or No)
If yes, name country

3 (a) FULL NAME WALTER B. SIWINSKI

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Barbara
6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) 2/2/83

8. AGE: Years	Months	Days	If less than one day
62	9	1	hr. min.

9. Birthplace Sierpc, Poland (Town, county, and state)
10. Usual Occupation Dentist
11. Industry or business

FATHER
12. Name Joseph Siwinski
13. Birthplace Poland

MOTHER
14. Maiden Name Wiela Wisielewska
15. Birthplace Poland

16 (a) Informant Mrs. Barbara J. Siwinski
(b) Address 3907 Juniper Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/7/45 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location German Hill Road

18 (a) Funeral director M. J. Tatlow & Sons
(b) Address 180 S. Eastern Ave.

19 1945 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 3, 1945 at 9-10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-1-1945 to 11-3-1945 and that I last saw h alive on 11-3-1945.

Immediate cause of death Cardiac tamponade — Duration

Due to Rupture anterior surface left ventricle

Due to Anterior coronary occlusion with infarction

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy Rupture left ventricle Cardiac tamponade

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Eugene J. Riley, M.D.
Address 1400 N Caroline Date signed 11/3/45

VS 150

633930 [GREISER] BALTIMORE CITY HEALTH DEPARTMENT Registered No. 633930

CERTIFICATE OF DEATH 124a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 15 Oakleaf Village (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henrietta L. Greiser

3 (b) If veteran, name war None
3 (c) Social Security Account No. ?

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: George H.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 3rd 1897

8. AGE: Years 48 | Months 7 | Days 5 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Herman Henry Deukes

13. Birthplace Germany

MOTHER 14. Maiden name Augusta Bertha Dorothea Gerhardt

15. Birthplace Baltimore Md

16 (a) Informant Julia Anna Tennant

(b) Address 18 S. Beechfield Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 8-1945 (month) (day) (year)

(c) Cemetery or crematory Baltimore City

Location

18 (a) Funeral director Wm. H. & B. M. Walter

(b) Address Pratt & Stricker Sts

19 (a) NOV 6 - 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 5th 1945, at 1:30 P.M

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cirrhosis of Liver, Fatty degeneration of Liver

Due to Chronic alcoholism

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury At M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Robert C. Graham M.D. Medical Examiner.

Date signed 11-5-45

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G33931

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 58 B

G33931 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3108 Strickland St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3108 Strickland St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eileen J. Morris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 12 - 1934

8. AGE: Years 11 | Months 0 | Days 23 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation School Girl

11. Industry or business

FATHER 12. Name Wilbur B. Morris

13. Birthplace Balto Md

MOTHER 14. Maiden Name Anna J. Blockert

15. Birthplace Balto Md

16 (a) Informant Anna J. Morris

(b) Address 3108 Strickland St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 8-1945 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location City

18 (a) Funeral director J. H. C. & B. M. Walker

(b) Address Baltimore

19 Nov 6 1945 (Date rec'd by Reg.) (b) Huntington Williams M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 4 1945 at 1 05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 17 1945 to Nov 4 1945 and that I last saw him alive on Nov 4 1945

Immediate cause of death Endocarditis

Due to Rheumatism

Due to Nephritis

Other Conditions Pulmonary Oedema

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert C. Nelson M. D.

Address 2151 Madison Ave Date signed 11/6/45

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

633932

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 633932

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Owings Mills
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edwin Warren White

3 (b) If veteran, name war: No
3 (c) Social Security Account No. 217-05-5914

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Hattie P. White
6 (c) If dead, give age: 2 years

7. Birth date of deceased (mo., day, yr.) March 17, 1880

8. AGE: Years 65 | Months 7 | Days 15 | If less than one day: hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Eggleston S. White
13. Birthplace Lexington Va.

MOTHER
14. Maiden Name Laura M. Hurman
15. Birthplace Balto. Md.

16 (a) Informant Hattie P. White
(b) Address Owings Mills, R.D. Md

17 (a) (Burial, cremation, or removal) (b) Date thereof 11/8/45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md

18 (a) Funeral director Ellis S. White
(b) Address 2840 Old Frederick Lane

NOV 6 - 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/5 1945 at 5 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/1 1945 to 11/5 1945, and that I last saw him alive on 11/5 1945.

Immediate cause of death: Peripheral circulatory collapse — Duration: 23 days in hospital
Due to: Cerebral accident
Due to: Hypertension
Other Conditions: Prostatic hypertrophy, bladder atony
(Include pregnancy within 3 months of death)
Date of operation 10/24/45
Major findings of operation: Prostatic hypertrophy (benign)
of autopsy: NONE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles W. Stewart, Jr. M.D.
Address Md. Gen. Hosp. Date signed 11/5/45

X

G33933

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

G33933
Registered No.

write the causes of death clearly and legibly. Physicians: please write

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3714 Gough St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ettore Cardarelli

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 6, 1901

8. AGE: Years 46 | Months 6 | Days 28 | If less than one day hr. min.

9. Birthplace Italy
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Domenico Cardarelli
13. Birthplace Italy

MOTHER
14. Maiden Name Crescenza Sammuro
15. Birthplace Italy

16 (a) Informant Pasquale Cardarelli brother
(b) Address 1016 S. Dupont Ave Cleveland O

17 (a) Burial (b) Date thereof Nov 7 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Wendell J. Leppel
(b) Address 312 S. Highland Ave

19 (a) 1945 Huntington Williams
(Date received by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 4 1945, at 9:10 a. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Fracture of skull, Fracture of neck

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-4-45 1/1 5:50 P.M.
(b) Where did injury occur? Pier I, Clinton St.
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury Fell down shaft

23. Signature Benedict Sbarretti M.D.
Medical Examiner.
Date signed 11-4-45

633934

AB-95840

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

633934 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2mos-2days
(e) Length of stay in Baltimore (yrs., mos., or days) 34yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1527 Cox St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Estelle Almond

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-14-0507

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Judson
6 (c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr.) June 12-1909

8. AGE: Years	Months	Days	If less than one day
36	4	22	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Small Parts Painter
11. Industry or business Balmar Corp.

FATHER
12. Name William
13. Birthplace Md.

MOTHER
14. Maiden Name Bertha Bussy
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 7 1945 (month) (day) (year)
(c) Cemetery or crematory Baltimore Hill
Location Bergen Klyn

18 (a) Funeral director Lehmann Smith & Son
(b) Address 2613-7 Chestnut Ave.

19 (a) NOV 7 - 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 4- 1945, at 10.25P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-2- 1945 to 11-4 1945 and that I last saw her alive on 11-4- 1945

Immediate cause of death	Duration
Cachexia	
due to generalized Carcinomatosis	9 Mo.
Due to Ca of rectum	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Eugene A. Patterson M. D.
Address BCH Date signed 11-5-45

VS 150

633935

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 633935

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkins & Caton Aves
(c) Hospital or institution: St. Agnes Hospt. No
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3432 N. Caton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Mr. Peter T. Tucker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Retta A. Graber

6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) March 7 1871

8. AGE: Years 74 | Months 7 | Days 30 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Charles Graber

13. Birthplace Unknown

MOTHER 14. Maiden Name —

15. Birthplace —

16 (a) Informant Son Charles A.

(b) Address 3432 N. Caton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 8 1945 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Baltimore Md

18 (a) Funeral director George W. Fetter

(b) Address 2760 Edmondson Ave

19 (a) (Signature) (b) Huntington Williams, Registrar

NOV 9 1945

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/6 1945 at 3 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/5 1945 to 11/6 1945 and that I last saw h. l. alive on 11/6 1945

Immediate cause of death Exsanguination

Due to Uncontrollable nasal Hemorrhage

Due to Hypertensive C-Vdis.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chas E. Carroll M.D.

Address St. Agnes Hospt. Date signed 11/6/45

X

G33936

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. G33936

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 312 N. Wolfe St.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Jennings

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black.	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10 30 45

8. AGE: Years	Months	Days	If less than one day
			13 hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name
13. Birthplace

MOTHER 14. Maiden Name Lois Jennings
15. Birthplace

16 (a) Informant Rhonda.
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical Schoo NOV 6 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 (Date rec'd by registrar) NOV 7 1945 Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 30. 1945 at 11. P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 30 1945 to Oct. 30 1945. and that I last saw her alive on Oct. 30 1945.

Immediate cause of death	Duration
respiratory failure	
Due to Effusion	3 hr.
Due to	
Other Conditions Prematurity	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. W. Mongan Jr.
Address Johns Hopkins Hosp. Date signed 10/31/45 M. D.

VS 150

3066

G33937

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G33937 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Fill correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: The Johns Hopkins Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 days
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 924 Shields Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mobley

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 30, 1945

8. AGE: Years	Months	Days	If less than one day
			1 hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Wilbur Johnson
13. Birthplace Maryland

MOTHER
14. Maiden Name Brunetta Mobley
15. Birthplace Maryland

16 (a) Informant Hospital Records
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School NOV 6 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 NOV 7 1945 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 30, 1945, at 4:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from October 30 1945 to October 30 1945, and that I last saw her alive on October 30 1945.

Immediate cause of death	Duration
prematurity	
atelectasis	
? congenital abnormalities	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Gilbert J. Vosburgh M. D.
Address Date signed

3067

X

G33938

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160a

Registered No. G33938

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every question must be answered. Information should be given in full. Ditto marks should not be used. Be sure the cause of death is clearly and legibly stated. Underlining the correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: The Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 713 Eislen Street
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Jordan

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Single

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 30, 1945

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation.....
11. Industry or business

FATHER
12. Name Charles Jordan
13. Birthplace Virginia

MOTHER
14. Maiden Name Carrie Murray
15. Birthplace Maryland

16 (a) Informant Hospital Records
(b) Address

17 (a)..... (b) Date thereof.....
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory.....
Location Johns Hopkins Medical School NOV 6 1945
18 (a) Funeral director Commissioner of Health
(b) Address.....
19 NOV 7 1945 Date rec'd by registrar Lemington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 31 1945, at 10:1[illegible] PM

21. I certify that death occurred on the date above stated; that I attended deceased from October 30 19 45 to October 31 1945, and that I last saw him alive on October 31 1945.

Immediate cause of death	Duration
atelectasis	
? Intracranial hemorrhage	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....
23. Signature Albert J. Vabrugh M. D.
Address..... Date signed.....

VS 150

13065

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G33939

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 134a

Registered No. G33939

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument + Rutland
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 7 days.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5004 Denmore Ave #15
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wm. B. Matthews

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Lillian Clarke

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 6 1886

8. AGE: Years	Months	Days	If less than one day
59	6	30	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Director

11. Industry or business Public Health

FATHER
12. Name William S. Matthews
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Emerald A. Dixon
15. Birthplace Baltimore Md.

16 (a) Informant Lillian C. Matthews
(b) Address 5004 Denmore Ave

17 (a) Burial (b) Date thereof 11-7-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Woodlawn
Location Woodlawn Md.

18 (a) Funeral director Loring Byers
(b) Address 5005 Park Ave Baltimore

19 (a) NOV 7 - 1945
(Date received by registrar) (Registrar)

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-5-45 19 at 5:30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/29 1945 to 11/5 1945
and that I last saw h[illegible] alive on 11/5/45 19

Immediate cause of death Coronary artery disease — Duration

Due to Arteriosclerosis

Due to

Other Conditions Pulmonary edema
Rt. Renal calculus
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Bertha Rader

Address Sinai Hosp. Date signed 11/5/45

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G33940 ✓ G33940 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 703 Fleet Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 W
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State ✓ (b) County
(c) City or town Blackstone Apts
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dr. Samd S. Blackman Jr.

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife ✓

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15 1917

8. AGE: Years 44 | Months 5 | Days 22 | If less than one day hr. min. 25 1001

9. Birthplace Texas.
(Town, county, and state)

10. Usual Occupation Physician

11. Industry or business

FATHER 12. Name Sam S. Blackman

13. Birthplace Texas.

MOTHER 14. Maiden Name Mary Book

15. Birthplace Texas

16 (a) Informant Miss Phyllis Rowe

(b) Address 14 E. Biddle St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 8/45 (month) (day) (year)

(c) Cemetery or crematory Greenmount Cem.

Location Baltimore Md.

18 (a) Funeral director John O. Mitchell & Sons

(b) Address 1916 Eutaw Place

19 (a) (Signature of local registrar) (b) Registrar

NOV 7 - 1945 Huntingtown Maryland

MEDICAL CERTIFICATION

20. DATE OF DEATH November 6, 1945, at 10. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury missing since Oct. 28, 1945 at M.
(b) Where did injury occur? 7 ft. Fall.
(c) Did injury occur at home, on farm, industrial place, in public place? Public. While at work? No.
(d) Means of injury Drowning.

23. Signature Robert Lee Feather M.D.
Medical Examiner.
Date signed Nov. 6 1945

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G33941

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registration No. G33941

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3616 Wilkens Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3616 Wilkens Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry D. Wolf

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Carrie E. Wolf (nee Lang)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 18, 1875.

8. AGE: Years 70 | Months 3 | Days 15 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Butcher

11. Industry or business

FATHER
12. Name Andrew Wolf
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Carrie E. Wolf
(b) Address 3616 Wilkens Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 7/45. (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Rd.

18 (a) Funeral director Harry H. Weitzke
(b) Address 4101 Edmondson Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 3 1945, at 9:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 31 1935 to Nov. 3 1945 and that I last saw him alive on Nov. 3 1945.

Immediate cause of death Coronary Occlusion — Duration 10/30/45

Due to Arteriosclerosis — 3 yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury —

23. Signature Earl B. Rosenberg M. D.

Address 1326 N. Lombard St. Date signed 11/6/45

VS 150 NOV 7 - 1945 Huntington Williams, M.D.

G33942

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G33942 Registered No. 41

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 302 N Pearl St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 302 N Pearl St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Catano

3 (b) If veteran, name war: W
3 (c) Social Security Account No. 217-03-7891

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Joseph
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 1886

8. AGE: Years: about 59 | Months | Days | If less than one day: hr. min.

9. Birthplace: Italy (Town, county, and state)

10. Usual Occupation: Seamstress

11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant: Mrs Emma Stapleton
(b) Address: 302 N Pearl St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/8/45 (month) (day) (year)
(c) Cemetery or crematory: Cathedral
Location: Balto. Md.

18 (a) Funeral director: Wilhom & Son Inc
(b) Address: 317 E Lon St

19 (a) (Date) (b) (Registrar) Nov 7 1945 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 6 1945, at 1 G M

21. I certify that death occurred on the date above stated; that I attended deceased from 5 Nov 1945 to 5 Nov 1945 and that I last saw h[illegible] alive on 5 Nov 1945

Immediate cause of death
Art Scl. C.V. Disease — Duration 1 yr
Myocardial Failure — 3 days
Due to
Due to
Other Conditions: Diabetes Mellitus
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence [illegible] at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
Signature: [illegible]
Address: 3400 [illegible] Date signed Nov 6, 1945

93D

633943

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 633943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 421 N.Broadway
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 421 N.Broadway
(If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Fink

3 (b) If veteran, name war	3 (c) Social Security Account No.
---	----

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife John Fink
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 7, 1863

8. AGE: Years	Months	Days	If less than one day
82	5	26	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Charles Hildebrand
13. Birthplace Germany

MOTHER
14. Maiden Name Mary ---
15. Birthplace Germany

16 (a) Informant Mr. John Fink
(b) Address 421 N.Broadway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 7/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Balto. Md.

18 (a) Funeral director Chilcis & Heuring Sons
(b) Address 2024 Orleans St.

19 (a) Nov 7 1945 (Date rec'd by local registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 3/1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 12 - 1945 to Nov 3 - 1945; and that I last saw [illegible] alive on Nov 3 - 1945.

Immediate cause of death
Myocardial insufficiency
Pulmonary Edema
Due to Arteriosclerosis.
Due to Chr. Arteriosclerosis & Hypertension

Duration
10 D
4 yrs.
24 yrs

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature John V. Keyser M.D.
Address 156 W. Mulberry St Date signed 11/5/45 M.D.

G33944

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G33944 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 W 40th St
(c) Hospital or institution:
Home For Incurables - 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4yrs 5mo
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State md — (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 700 W 40th St
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Emily Howard Ball

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 21 - 1856

8. AGE: Years	Months	Days	If less than one day
88	8	17	hr. min.

9. Birthplace Maryland - B-
(Town, county, and state)
10. Usual Occupation —
11. Industry or business

FATHER
12. Name Philip A. Ball
13. Birthplace Culpeper - Va

MOTHER
14. Maiden Name Emily Latimer
15. Birthplace Baltimore Md

16 (a) Informant Mrs. Wharton (Wolff)
(b) Address 700 W 40th St

17 (a) Burial (b) Date thereof 11-7-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Balto. Md.

18 (a) Funeral director STEWART & MOWER COMPANY
(b) Address (W. F. WOODEN SUC.) 106 N. HOWARD AVENUE

19 (a) (Date received by Local Registrar) NOV 7 1945 Huntington Hollow, Md. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 6th 1945, at 10:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 18th 1941, to Nov. 6th 1945, and that I last saw her alive on Nov. 6th 1945.

	Duration
Immediate cause of death Coronary Thrombosis	1 week
Due to Hypertensive Cardio-Vascular Disease	10 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Thomas Conrad Wolff
Address 11 E. Chase St. Date signed 11/8/1945
Baltimore 2 Maryland

PLEASE WRITE PLAINLY, with unfading ink. Examine the certificate after it is written and make sure that all items are complete and correct. Be sure the causes of death are clearly and legibly stated, and that the correct age is especially important. Physicians: please write the

G33945

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G33945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 907 Pierce St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 907 Pierce St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edwin B. Courtney

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F. | 5. Color or race C. | 6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife JAMES

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-19-1892

8. AGE: Years 53 | Months 2 | Days 14 | If less than one day hr. min.

9. Birthplace Cambridge, Md.
(Town, county, and state)

10. Usual Occupation AMMUNITION HANDLER.

11. Industry or business Edgewood ARSENAL

FATHER 12. Name Edward P. Bowley

13. Birthplace Md.

MOTHER 14. Maiden Name SARAH Johnson

15. Birthplace Md

16 (a) Informant BURDADINA ADAMS

(b) Address 907 Pierce St.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 11-7-45 (month) (day) (year)

(c) Cemetery or crematory MT. AUBURN

Location

18 (a) Funeral director Joseph S. Lockard

(b) Address 1304 N. Central Ave

19 (a) (Date rec'd by registrar) Huntington-Williams Mort

NOV 7 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-3 1945, at 3:35 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 25 1945 to Nov 3 1945, and that I last saw h[illegible] alive on Nov 3 1945.

Immediate cause of death

Due to Cerebral Hemorrhage — Duration 1 Week

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles T. Woodland M. D.

Address 761 Hanover St Date signed 11-3-45

CHARLES T. WOODLAND

G33946

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122a

Registered No. G33946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours 26
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 25 N. East Avenue
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Frances Novak

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or ~~wife~~ John Novak
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 16, 1889

8. AGE: Years	Months	Days	If less than one day
55	11	19	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation H.W.
11. Industry or business

FATHER
12. Name Frank Jaworski
13. Birthplace Germany

MOTHER
14. Maiden Name Mollie Karwacki
15. Birthplace Poland

16 (a) Informant John Novak (husband)
(b) Address 25 N. East Avenue

17 (a) Burial (b) Date thereof 11/8/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or ~~crematory~~ St. Stanislaus
Location Mt. Carmel Road. Balto. Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street

19 (a) NOV 7 - 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/5/1945, at 8:52 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/2/1945 to 11/5/1945 and that I last saw her alive on 11/5/1945

Immediate cause of death: Congestive Heart Failure — Duration 48hrs.
Due to Hypertensive C.V. Disease
Due to Post-Op.-Incar. Hernia
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 11/3/45
Major findings of operation: Incar Hernia -
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John Novak Jr.
Address Bon Secours Hosp. Date signed 11/5/45

VS 150

G33947

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

178 X

Registered No. G33947

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 d. 0 hr.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. County
(b) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 414 N. Chester Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Elmer Conner

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-09-0231

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Nettie (nee Henkel)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 5, 1881

8. AGE: Years	Months	Days	If less than one day
64 yrs.	8	29	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business American Raincoat Co.

FATHER
12. Name Joseph Conner
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name unknown
15. Birthplace "

16 (a) Informant wife
(b) Address 414 N. Chester Street

17 (a) Burial (b) Date thereof 11/7/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North Ave. & Rose St. Balto. Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street

19 (a) NOV 7 - 1945 (b) Huntington Mills Baltimore Md.
(Date rec'd by registrar)

VS t51

MEDICAL CERTIFICATION

20. DATE OF DEATH November 4, 45 1945, at 4 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Live death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation due to smoke.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 6/4
(a) Date of injury 11-4-45 at 3:40 P.M.
(b) Where did injury occur? 414 N. Chester Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home. While at work? No.
(d) Means of injury Mattress caught fire.

23. Signature John L. Ward, M.D.
Medical Examiner.
Date signed November 6, 1945.

117

X

Please write plainly, using ink. Physicians: please write the causes of death clearly and legibly. Cause of death and correct age is especially important.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G33948

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G33948 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 526 S. Chapel Gate Lane
(c) Hospital or institution:
Ventnor Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Kensington
(If outside city or town limits, write RURAL and give town)
(d) Street No. 39 S urragate Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JULIA M. WAGNER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife Charles S. Wagner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 15, 1870

8. AGE: Years	Months	Days	If less than one day
75	4	22	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John P. Allen
13. Birthplace Md.

MOTHER
14. Maiden Name Sophia Cox
15. Birthplace Md.

16 (a) Informant Mrs. Raymond Berdoff
(b) Address 39 Surragate Rd., Kensington

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/10/45 (month) (day) (year)
(c) Cemetery or crematory Rockville Union
Location Rockville, Md.

18 (a) Funeral director REUBEN PUMPHREY
(b) Address 300 W. Montgomery Ave Rockville, Md.

19 (a) (Date rec'd by Registrar) (b) Registrar

NOV 7 - 1945 Huntington Williams, M.D.

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 7, 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 12 1945, to Nov 7 1945.
and that I last saw her alive on Nov 7 1945

Immediate cause of death	Duration
Coronary Occlusion	2 days
Due to	
Due to	
Other Conditions General Arteriosclerosis	?

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Williams M. D.
Address 330 Medical Arts Bldg. Date signed

X

G33949

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G33949 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 1524
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City, Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2100 Linden St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Kennedy

3 (b) If veteran, name war

3 (c) Social Security Account No. Did not get

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M ?

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4 - 1878

8. AGE: Years	Months	Days	If less than one day
67	4	1	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Stonemason

11. Industry or business

FATHER
12. Name James Thomas Kennedy
13. Birthplace Ireland

MOTHER
14. Maiden Name Unknown
15. Birthplace Ireland

16 (a) Informant Patrick Joseph Kennedy
(b) Address 450 W. 25th St - Balto

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 8 - 1945 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemetery
Location Baltimore Md.

18 (a) Funeral director Morris Cook Sypes
(b) Address 1600 W. North Ave

19 (a) (Date received by Registrar) NOV 7 1945 (b) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/5 1945, at 9 20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/5 1945 to 11/5 1945 and that I last saw h[illegible] alive on 11/5 1945.

Immediate cause of death Cardio - Resp. Failure

	Duration
Due to Cardio - Vascular Disease	
Due to	
Other Conditions Diabetes	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. M. Scott M. D.
Address University Hosp. Date signed Nov. 6 1945

93D

G33950

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163M

G33950 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 100 Overhill Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1Y
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 100 West University Parkway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROBINS RICH ADAMS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Wht

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Howard Adams

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-2-1903

8. AGE: Years 40 | Months 6 | Days 4 | If less than one day hr. min.

9. Birthplace Catonsville Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Edward L. Rich

13. Birthplace Leisterstown Rd

MOTHER 14. Maiden Name Mary A. Sunderland

15. Birthplace Md.

16 (a) Informant Howard Adams Jr

(b) Address 100 Overhill Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 9th (month) (day) (year)

(c) Cemetery or crematory London Park

Location Baltimore Md

18 (a) Funeral director Henry W. Jenkins Sons Co.

(b) Address McCulloh & Orchard Sts.

19 (a) NOV 7 - 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/6/45 19..., at ...M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carbon Monoxide poisoning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 11/6 at 8:30 A. M.

(b) Where did injury occur? Garage back of 100 Overhill Road

(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No

(d) Means of injury Auto exhaust Asphyxiation

23. Signature John L. Wade M.D. Medical Examiner.

Date signed 11/7/45

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

AB-97023 G33951

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

G33951 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
9
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1704 N. Spring St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Kenneth Warren -or- Robert Kenneth Holland

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: C
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 3- 1943

8. AGE: Years 1 | Months 11 | Days 8 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Robert Warren
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Gray or Theodoshia Holland
15. Birthplace Indiana

16 (a) Informant Baltimore City Hospitals' Records
(b) Address 4940 Eastern Ave.

17 (a) Burned (Burial, cremation, or removal) (b) Date thereof 11-7-45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1100 Bentley ave

19 (a) Filed 11 7 1945 (Date rec'd by Registrar) (b) Registrar

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 4- 19 45, at 2.45P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-31- 19 45, to 11-4- 19 45 and that I last saw h 1Falive on 11-4- 19 45

Immediate cause of death: Tuberculosis Meningitis — Duration: 6 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy: Miliary Tuberculosis Tuberculous Meningitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter M Tarsen M. D.

Address B C H Date signed 11/5/45

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

G33952

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 94a

Registered No. G33952

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 717 N. Monroe St.
(c) Hospital or institution: ~
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 16
(e) Length of stay in Baltimore (yrs., mos., or days) ~

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County USA
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 717 N. Monroe (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country ~

3 (a) FULL NAME John W. G. Karns.
3 (b) If veteran, name war No. | 3 (c) Social Security Account No. ~
4. Sex M | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced Widowed
6 (b) Name of husband or wife Myrtle E. Karns
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 6-19-1872
8. AGE: Years 73 | Months 4 | Days 16 | If less than one day ___ hr. ___ min.
9. Birthplace Tarentum Penna. (Town, county and state)
10. Usual Occupation Bottle Blower.
11. Industry or business Carlyle Glass Co.
FATHER 12. Name John Karns.
13. Birthplace Penna.
MOTHER 14. Maiden Name Martha Gebhard.
15. Birthplace Penna.
16 (a) Informant John F. Karns.
(b) Address 717 N. Monroe St
17 (a) Burial (b) Date thereof 11-8-45 (month) (day) (year)
(c) Cemetery Lorraine Park
Location Woodlawn Md.
18 (a) Funeral director Edwin W. Fuhrmann
(b) Address 703 McHenry St.
19 (a) (Date received by registrar) (b) Huntington Williams, M.D.
NOV 7 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 5 19 45, at 1 P M
21. I certify that death occurred on the date above stated; that I attended deceased from Nov 4 1945 to Nov 5 1945 and that I last saw him alive on Nov 5 1945

Immediate cause of death	Duration
respiratory failure	
Due to coronary occlusion	
Due to Generalized Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature S. Borofsky M.D.
Address 601 N. Monroe St Date signed 11/9/45 M. D.
X S Borofsky.

VS 150

G33953

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1318

Registered No. G33953

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4700 Harford Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 4700 Harford Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Elizabeth Gray

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 5th 1868

8. AGE: Years 77 | Months 6 | Days - | If less than one day: hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George Feller
13. Birthplace Md

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Mrs Grey
(b) Address 1615 N Wolfe St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 9th 1945 (month) (day) (year)
(c) Cemetery or crematory Balto.
Location E North Ave Ext

18 (a) Funeral director Leo G. Cook
(b) Address 1201-03 N Patterson Park ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams, Registrar
VS 150 NOV 7 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 5th 1945, at 8:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 7- 1943 to Nov 5- 1943, and that I last saw her alive on Nov 3- 1945.

Immediate cause of death	Duration
Edema of Lungs	1 day
Due to Chronic Myocarditis	2 yrs
Due to	
Other Conditions Chronic Nephritis	2 yrs

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. Gill Hall M. D.
Address 1631 2 North av Date signed 11/6/45

G33954

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1860

Registered No. G33954

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, 18.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1533 Ralworth Rd.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Bertha L. Heer (BERTHA LOHRMANN HEER)

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: William Heer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 22, 1861

8. AGE: Years 83 | Months 11 | Days 14 | If less than one day hr. min.

9. Birthplace Maryland.
(Town, county, and state)

10. Usual Occupation None.
11. Industry or business

FATHER
12. Name Micheal Lohrmann
13. Birthplace Germany

MOTHER
14. Maiden Name Sybilla ?
15. Birthplace Germany

16 (a) Informant Miss Sybilla C Heer.
(b) Address 1533 Ralworth Rd, Balto 18.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-9-45 (month) (day) (year)
(c) Cemetery or crematory DRUID RIDGE CEM.
Location BALTIMORE, MARYLAND

18 (a) Funeral director HENRY SANDER & SONS, INC?
(b) Address NORTH AVE. & BROADWAY

19 NOV 7 - 1945 (c) Name of Reg. Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-6-45 19 , at 2.55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 14 1945 to 11-6 1945 and that I last saw h.er alive on 11-5- 1945

Immediate cause of death: Cardiac failure — Duration
Due to: Degenerative CVD.
Due to:
Other Conditions: Intertrochanteric fr. left femur.
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence October 13, 1945 M
(c) Where did injury occur? Baltimore, Md.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? at home While at work? no
(Specify type of place)
(e) Means of injury: Slipped + fell on floor

23. Signature Dayle E Arnold M. D.
Address 1101 N. Ca. Date signed 11-6-45

VS 150

Howard J. Williams M. D.

G33955

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G33955

CWK-89368

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1- 2- 18
(e) Length of stay in Baltimore (yrs., mos., or days) 23 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1324 Riggs Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Paxton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Separated

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25-1878

8. AGE: Years 66 | Months 10 | Days 5 | If less than one day hr. min.

9. Birthplace North Carolina
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Abraham Paxton
13. Birthplace North Carolina

MOTHER
14. Maiden Name Amy Skinner
15. Birthplace North Carolina

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-7-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Balto. Md.

18 (a) Funeral director William A. Jackson
(b) Address 916 Penna Ave

NOV 7 - 1945 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 30 1945, at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 22 1945, to Oct. 30 1945, and that I last saw him alive on Oct. 30 1945.

	Duration
Immediate cause of death: Cardiac decompensation	2 wks
Due to: Arteriosclerosis & Chronic Nephritis	2 yrs
Due to:	
Other Conditions: Arteriosclerosis	4 wks

(Include pregnancy within 3 months of death)

Date of operation 10-23-45

Major findings of operation: as above

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas J. O'Neill M. D.
Address Balto. City Hosps Date signed 11-6-45

VS 150

G33956

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157a

G33956 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: 401 W. Lanvale St.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 401 W. Lanvale St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Walter C. Taylor

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/19/45

8. AGE: Years | Months: 7 | Days: 18 | If less than one day: hr. min.

9. Birthplace Balto Md. (Town, county, and state)
10. Usual Occupation Child
11. Industry or business

FATHER
12. Name Walter Taylor Sr.
13. Birthplace Va.

MOTHER
14. Maiden Name Bettie Yellidie
15. Birthplace NC

16 (a) Informant Walter Taylor
(b) Address 401 Lanvale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-8-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Cedar Hill Md.

18 (a) Funeral director Solomons Halstead
(b) Address 918 Druid Hill Ave.

NOV 7 - 1945 (Date rec'd by Registrar) (b) Huntington Hollins, Md. (Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 7th 1945, at 12 45 A.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Congenital Hydrocephalus

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mendelsohn M.D. (Medical Examiner.)
Date signed 11-7-45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

633957

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 633957

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2102 E Lombard St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2102 E. Lombard St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Margaret Kaminski

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	M.

6 (b) Name of husband or wife Martin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1889

8. AGE: Years	Months	Days	If less than one day
56			hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George Stroble
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Doyle
15. Birthplace Balto. Md.

16 (a) Informant Martin Kaminski
(b) Address 2102 E. Lombard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-8-45 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Balto. Co.

18 (a) Funeral director Wm. L. Fiallowski
(b) Address 2007 Eastern Ave

19 (a) Filed [illegible] 1945 (b) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 4th 1945, at 9 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 18 1945 to Nov 4 1945
and that I last saw h[illegible] alive on Nov 4th 1945

Immediate cause of death	Duration
Coronary occlusion	4 days
Due to Hypertension	2
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature H. J. Rankin M. D.
Address 100 N. Milton Ave Date signed 11/6/45

22. H. J. RANKIN 100 N. MILTON AVE

633958

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 83a

Registered No. 633958

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 609 S. Patterson Pk Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 609 S. Patterson Pk. Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** MARCELI - M. ~~MICHALSKI~~ MICHALSKI

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	M.

6 (b) Name of husband or wife Julia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years	Months	Days	If less than one day
71			hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Cabinet Maker

11. Industry or business Standard Store Equipment

FATHER
12. Name —
13. Birthplace Poland

MOTHER
14. Maiden Name —
15. Birthplace Poland

16 (a) Informant Julia Michalski
(b) Address 609 S. Patterson Pk. Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-8-45 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Balto. Co.

18 (a) Funeral director Wm. S. Fialkowski
(b) Address 2007 Eastern ave

19 Filed Nov 7 1945 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 4 1945, at 11:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 3 1945 to Nov 4 1945; and that I last saw h— alive on Nov. 4 1945.

Immediate cause of death	Duration
Cerebral Apoplexy	acute
Due to Cerebral Arterio-sclerosis & Hypertension	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chas. J. Semple M.D.
Address 5002 E. Baltimore Date signed 11/5/45

VS 150

G33959

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 108

G33959 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Greene & Redwood Sts.
(c) Hospital or institution: University Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 2200 Riggs Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Bertha E. Herzog

3 (b) If veteran, name war —

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Philip J. Herzog
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept. 29-1855

8. AGE: Years	Months	Days	If less than one day
90	1	8	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER 12. Name Bernard Schone
13. Birthplace Germany

MOTHER 14. Maiden Name Angela Taplora
15. Birthplace Germany

16 (a) Informant J. Carroll Herzog
(b) Address 3027 Brookmont Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-9-45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director G. Howard Strong
(b) Address 3707 W. North Ave.

19 (a) NOV 7 - 1945 (Date received by registrar) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/6 1945, at 1:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/27 1945 to 11/6 1945, and that I last saw her alive on 11/6 1945.

Immediate cause of death Respiratory failure — Duration

Due to Lobar pneumonia

Due to (over)

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John M. Dennis M. D.
Address University Hospital Date signed 11/6/45

X

Dr. 633960

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G33960 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5401 Carter Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5401 Carter Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Clara Rudiger Gantz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
F	W	widowed

6 (b) Name of husband or wife Charles H.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 27, 1877

8. AGE: Years	Months	Days	If less than one day
68	1	11	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Cathryne A. Everett
(b) Address 5401 Carter Avenue -14-

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/10/45 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) (Date rec'd by registrar) Huntington Williams MR (Registrar)

Nov 7 - 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 7, 1945, at 2 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 27 1942 to Nov 6 1945, and that I last saw h[illegible] alive on Nov 6 1945

Immediate cause of death Cerebral Hemorrhage — Duration 5 days
Due to Hypertension
Chronic myocarditis
Due to Arteriosclerosis
Other Conditions Rt hemiplegia
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. W. Harrold M.D.
Address 4706 Harford Road signed 11/7/45

G33961

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. G33961

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: So. Balto. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 320 Washburn Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Lester A. Mackebee

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Freda Mackebee
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 27th 1900

8. AGE: Years	Months	Days	If less than one day
44	11 10	8	hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business Glenn L. Martin

FATHER
12. Name Richard O. Mackebee
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary C. Lloyd
15. Birthplace Maryland

16 (a) Informant Mrs. Lester A. Mackebee
(b) Address 320 Washburn Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof 11/8/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Flynn & Fleming
(b) Address 1426 Light St.

19 (a) Registered (b) Huntington Williamsport, Md.

NOV 7 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 5, 1945, at 11:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 5, 1945 to Nov 5, 1945, and that I last saw him alive on Nov. 5, 1945

Immediate cause of death	Duration
Coronary thrombosis	
Due to Hypertension	
Due to Cardiac vascular disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Coronary thrombosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Durbin
Address 1213 Light St. Date signed 11-8-45

X

G33962

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

G33962
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & CALVERT STREETS
(c) Hospital or institution:
UNION MEMORIAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State PA. (b) County YORK
(c) City or town YORK
(If outside city or town limits, write RURAL and give town)
(d) Street No. 242 JEFFERSON AVE.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country —

3 (a) FULL NAME Miss MARIE A. SMITH

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	SINGLE

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) JAN. 24, 1893

8. AGE: Years	Months	Days	If less than one day
52	10	13	— hr. — min.

9. Birthplace PENNSYLVANIA (Town, county, and state)

10. Usual Occupation FLORIST

11. Industry or business —

FATHER
12. Name CHARLES E. SMITH
13. Birthplace PENNSYLVANIA

MOTHER
14. Maiden Name EMMA SIECK
15. Birthplace BALTIMORE, MD.

16 (a) Informant SISTER - MRS. C. GRIFFITH
(b) Address 31 N. BEAVER ST. - YORK, PA.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 10-45 (month) (day) (year)
(c) Cemetery or crematory Prospect Hill Pa.
Location York Penna

18 (a) Funeral director William Cook Inc
(b) Address 1217 St Paul Street

19 (a) (Date rec'd by registrar) NOV 7 - 1945 (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH NOVEMBER 6, 1945, at 11:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 30, 1945, to Nov. 6, 1945 and that I last saw h[illegible] alive on Nov. 6, 1945

Immediate cause of death — Duration

cardiac failure

Due to myocardial infarction

Due to

arteriosclerotic heart disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Oct. 31, 1945

Major findings of operation: TRAUMATIC HYPERTROPHIC ARTHRITIS, R. H[illegible]

of autopsy: myocardial infarction

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: N.Y.

(a) Accident, suicide, or homicide Accident, 9320 M

(b) Date of occurrence Unknown at

(c) Where did injury occur? Unknown
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? Unknown While at work? Unknown
(Specify type of place)

(e) Means of injury Jumping from moving automobile

23. Signature Crawford M. Kirkpatrick, Jr. M.D.

Address Union Memorial Hosp. Date signed 11-7-45

Howard J. Moreschi M.D.

633963

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 48a

633963
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
US Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 144 days
(e) Length of stay in Baltimore (yrs., mos., or days) 144 days

2. USUAL RESIDENCE OF DECEASED:
(a) State DC (b) County
(c) City or town Washington
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1300 Maine Ave. SW
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Wingert, Anna Catherine

3 (b) If veteran, name war

3 (c) Social Security Account No. 578-24-3943

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Otto Wingert
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) July 25, 1899

8. AGE: Years	Months	Days	If less than one day
46	3	11	hr. min.

9. Birthplace Newark, NJ (Town, county, and state)
10. Usual Occupation Hwf
11. Industry or business

FATHER
12. Name Charles Rittershoffer
13. Birthplace Newark, NJ

MOTHER
14. Maiden Name Hattie Mullen
15. Birthplace Long Island, NY

16 (a) Informant Records
(b) Address US Marine Hospital, Balto, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 10-45 (month) (day) (year)
(c) Cemetery or crematory Arlington Nat. Va.
Location Virginia

18 (a) Funeral director W W Chambers Co
(b) Address Washington D.C.

19 (a) (Date rec'd by registrar) (b) Registrar

NOV 7 - 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 6 1945 at 10:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 15 1945 to Nov. 6 1945, and that I last saw her alive on Nov. 6 1945.

Immediate cause of death Carcinoma cervix with metastasis to liver and retroperitoneal lymph nodes. — Duration 2 yrs

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address Clinical Director Date signed 11/7/45
US Marine Hospital, Balto, Md.

G33964

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √ 61

G33964 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 7 Mallow Hill Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7 Mallow Hill Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gertrude Pfeifer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 9, 1879.

8. AGE: Years 66 | Months 8 | Days 26 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Michael J. Pfeifer
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Yaeger
15. Birthplace Germany

16 (a) Informant Miss Amelda C. Costello
(b) Address 7 Mallow Hill Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 8/45. (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3801 Frederick Rd.

18 (a) Funeral director Harry H. Nitzle
(b) Address 4101 Edmondson Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

NOV 7 - 1945 Huntington Hollins, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 5, 1945, at 4 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1, 1942 to Nov. 5 1945, and that I last saw h.e alive on Nov. 4, 1945.

Immediate cause of death:	Duration
Nephritis (Chronic Par. enchymatous)	2 years
Due to Diabetes Mellitus	10 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Eugene L. Cavazos M. D.
Address 514 Druid Park Lane Date signed Nov. 6, 1945

X Personally

Dr. Gosley G33965
5100 Bk. Harford

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G33965
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2224 Lake Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2224 Lake Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Elizabeth Reinig

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	widowed

6 (b) Name of husband or wife Henry Reinig
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 14, 1876

8. AGE: Years	Months	Days	If less than one day
69	9	23	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name ? Butta
13. Birthplace Austria

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Eleanor Metzger
(b) Address 2224 Lake Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/10/45 (month) (day) (year)
(c) Cemetery or crematory Holy Reddeemer
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

NOV 7 - 1945 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 6, 1945; at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1945 to 11/6 1945 and that I last saw h alive on 11/6 1945.

Immediate cause of death Coronary Thrombosis. ?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Tyler W. Gosley M.D.
Address 5703 Harford Rd Date signed 11/7/45

G33966

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G33966 Registered No. 1310

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) ~~Hospital or institution~~: Union Memorial Hosp'l
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dec'd
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 1614 Shadyside Rd (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Katherine Costello

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife John F. Costello

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/9/1873

8. AGE: Years	Months	Days	If less than one day
72	7	27	hr. min.

9. Birthplace Bolto md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Edwd. McShane
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary McKenna
15. Birthplace Ireland

16 (a) Informant John. F. Costello
(b) Address 1614 Shadyside Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/10/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Bolto md

18 (a) Funeral director H. C. Brannan & Son
(b) Address 2924 Edmondson Ave

19 (a) (Signature of local registrar) (b) Huntington Williams, M.D.

NOV 8 1945

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 6th 1945, at 4:09 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebrovascular renal disease

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury.....M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?.....While at work?.....
(d) Means of injury.....

23. Signature Howard J. Mullen M.D. Medical Examiner.
Date signed 11-7-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entry must be complete and correct as to the causes of death clearly and legibly. Age is especially important. Physicians: please write the

G33967 • BALTIMORE CITY HEALTH DEPARTMENT Reg No. G33967

CERTIFICATE OF DEATH 94a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3304 Alameda Blvd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3304 Alameda Blvd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Frank Brown

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Black	Married

6 (b) Name of husband or wife Lillie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 5, 1880

8. AGE: Years	Months	Days	If less than one day
65	7	21	hr. min.

9. Birthplace Havre de Grace Md
(Town, county, and state)
10. Usual Occupation Mechanic
11. Industry or business Self

FATHER
12. Name Joseph Brown
13. Birthplace Md

MOTHER
14. Maiden Name Elizabeth Chalk
15. Birthplace Md

16 (a) Informant Lillie Chalk
(b) Address 3304 Alameda Blvd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/9/45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md

18 (a) Funeral director Wilson & Son
(b) Address 1214 E Fayette St

19 (a) (Date rec'd by registrar) (b) Registrar

NOV 8 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 6 1945, at 8:29 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 2 1945 to Nov 6 1945 and that I last saw h alive on Nov 6 1945

Immediate cause of death	Duration
Coronary Thrombosis	1-2 hours
Due to	
Due to	
Other Conditions Bronchitis Chronic	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. D.
Address 115 Chase Date signed

Geo. W. Mitchell X

G33968

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G33968 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Lombard + Greene Sts

(c) Hospital or institution: University Hosp 26

(d) Length of stay in hospital or inst (yrs., mos., or days) 2 days

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 4701 Frankford Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lennon M. Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 25 1929

8. AGE: Years 16 Months 3 Days 13 If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER

12. Name Wilbon Jones

13. Birthplace Baltimore Md

MOTHER

14. Maiden Name Margaret Suffle

15. Birthplace Baltimore Md

16 (a) Informant Margaret Jones

(b) Address 4701 Frankford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/10/45 (month) (day) (year)

(c) Cemetery or crematory Leverton Md

Location Baltimore Md

18 (a) Funeral director Wilbon Co Inc

(b) Address 1217 E Fayette St

19 (a) (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

WDS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-7 1945 at 4:00 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-5 1945 to 11-7 1945, and that I last saw h[illegible] alive on 11-7 1945.

Immediate cause of death Diabetic acidosis

5 acute pancreatitis

Due to Diabetes mellitus

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature E. L. Henry M. D.

Address Date signed

X

G33969

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G33969 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be answered. If unknown or if the question is not applicable, state which. Do not use ditto marks. Be sure that the cause of death is clearly and legibly stated. Any person who wilfully makes any false statement in this certificate shall be guilty of a misdemeanor and subject to the penalties prescribed by law. Also see that the age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1705 E. Biddle St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1705 E. Biddle St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Laura Hunter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband ~~or wife~~ James Hunter

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 10th 1869

8. AGE: Years	Months	Days	If less than one day
75	3	26	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business At Home

FATHER
12. Name George Harford
13. Birthplace Md.

MOTHER
14. Maiden Name Carrie ?
15. Birthplace Md.

16 (a) Informant Miss Etta Clough
(b) Address 1106 Homewood Ave

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 11/9/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) Huntington Williams M.D. Registrar
(Date rec'd by registrar)

NO 3 1945

WS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 6th 1945, at 3 P.M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Broncho-pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Moseley M.D.
Medical Examiner.
Date signed 11-7-45

G33970

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G33960

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway
(c) Hospital or institution:
Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll Balto.
(c) City or town Sykesville
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Graham Melville

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. M

6 (b) Name of ~~husband or~~ wife Helen M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 7 1889

8. AGE: Years 55 | Months 5 | Days 5 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Manufacturer

11. Industry or business

FATHER
12. Name John C. Melville
13. Birthplace Md.

MOTHER
14. Maiden Name Elsie Farmer
15. Birthplace Md.

16 (a) Informant Husb. Records.
(b) Address

17 (a) Burial (b) Date thereof Nov. 10, 1945
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Druid Ridge Cem.
Locaion Pikesville, Md.

18 (a) Funeral director C. Harry Weer
(b) Address Sykesville, Md.

19 (a) (b)
(Date rec'd by registrar) Huntington Williamsville

NOV 8 - 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-7 1945, at 9:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-7 1945 to 11-7 1945 and that I last saw him alive on 11-7 1945

	Duration
Immediate cause of death Acute Pulmonary Edema	36 hrs.
Due to Coronary Sclerosis	1 yr.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Francis M. Shipley M.D.

Address Church Home Hosp. Date signed

Every item of information should be carefully supplied. The age is especially important. Physicians: please write the causes of death clearly and legibly. WRITE PLAINLY, WITH UNFADING INK.

63971

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1216

Registration No. 63971

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland W.
(b) Street address 1153 Calhoun St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 1 year 4 mo

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1153 W. Calhoun St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Anderson

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	colored	Widowed

6 (b) Name of husband or wife Sallie Anderson
6 (c) If alive, give age —— years

7. Birth date of deceased (mo., day, yr.) April 22, 1871

8. AGE: Years	Months	Days	If less than one day
74	6	12	..... hr. ..... min.

9. Birthplace York S.C.
(Town, county, and state)
10. Usual Occupation Machine Operater
11. Industry or business Monarch Pa Wire Mills

FATHER
12. Name Jeff Anderson
13. Birthplace York S.C.

MOTHER
14. Maiden Name Rachel ?
15. Birthplace York S.C.

16 (a) Informant Mr Rachel Dodel
(b) Address 1153 Calhoun St.

17 (a) Burial (b) Date thereof Nov. 8, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Chas. H. Holland
(b) Address 1631 Druid Hill Ave.

19 NOV 8 - 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 — 4 — 1945 at 5:P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 6 1945 to 11-4-1945 and that I last saw him alive on 11-4-1945

Immediate cause of death Nephritis — Duration 2 years
Due to — Duration ——
Due to — Duration over
Other Conditions Myocarditis — Duration 1 year
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank A. Saunders M. D.
Address 1029 N. Stricker St. Date signed 11-6-45

X 17

G33972

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G33972

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1000 Caton Avenue
(c) Hospital or institution: Jenkins Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1902 Edmondson Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Howe

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 25, 1870

8. AGE: Years	Months	Days	If less than one day
75	2	12	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name John Howe
13. Birthplace Ireland

MOTHER
14. Maiden Name Bridget Hannon
15. Birthplace Ireland

16 (a) Informant Mrs. Augusta McMillan
(b) Address Bayside N.Y.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/9/45 (month) (day) (year)
(c) Cemetery or crematory St. Peters
Location Baltimore

18 (a) Funeral director Martin Fahey & Sons
(b) Address 1827 W. North Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

NOV 8 - 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 6, 1945, at 6 15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1st 1945, to Nov 6 1945, and that I last saw her alive on Nov 5th 1945.

Immediate cause of death	Duration
Cardiac failure	
Due to Arteriosclerosis	
Cardio vasc Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Clift Smith, Jr. M. D.
Address 25 Wyman Park Date signed Nov 6 45

X

G33973

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G33973

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 Old Spring Lane
(c) Hospital or institution: Old Spring Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2101 W Old Spring Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John T. Simmons Simmons

3 (b) If veteran, name war —

3 (c) Social Security Account No. 216-12-6426

4. Sex male | 5. Color or race white | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Margaret B

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 2nd 1867

8. AGE: Years 77 | Months 11 | Days 5. | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Lawyer

11. Industry or business Retired

FATHER 12. Name John Simmons

13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Waterson

15. Birthplace Baltimore Md

16 (a) Informant Mrs Margaret B Simmons

(b) Address 1160 W Lanvale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 10 44 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location 3801 Frederick Road

18 (a) Funeral director John J Cowan & Son

(b) Address 901-03 Hollins St.

19 (a) Received by [illegible] NOV 8 1944 Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 7th 1944, at 7:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 4 1944 to Nov. 7 1944 and that I last saw him alive on Nov. 6 1944.

Immediate cause of death	Duration
cerebral hemorrhage	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm H. Futterman M. D.

Address 7324 Reisterstown Rd Date signed 11/5/44

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G33974

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 44 B

Registered No. G33974

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai Hosp 15 9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits write RURAL and give town)
(d) Street No. 4004 Bonner Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Kate Cohen

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Wh	M

6 (b) Name of husband ~~or wife~~ Charles
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years	Months	Days	If less than one day
49			hr. min.

9. Birthplace Wash D.C. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Louis
13. Birthplace Russia

MOTHER
14. Maiden Name Golski
15. Birthplace Russia

16 (a) Informant Hospt Records.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-8-45 (month) (day) (year)
(c) Cemetery or crematory Beth Tfiloh
Location Wmsberg Blvd & Belair Rd

18 (a) Funeral director Jos. Feinberg
(b) Address 1439 E. Baltimore St

19 (a) NOV 8 - 1945 (Rec'd by registrar) By Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-7-45 19 , at 9:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-19 1945, to 11-7-1945, and that I last saw her alive on 11-7-1945.

Immediate cause of death Hodgkin's Disease — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Bertha Radev, M.D.
M. D.
Address Sinai Hosp. Date signed 11-7-45

VS 150

X

G33975

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61 ✓

G33975 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1507 E. 29th St.
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1507 E. 29th St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Emma May Baker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Charles L. Baker

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1, 1864

8. AGE: Years 81 | Months 6 | Days 5 | If less than one day hr. min.

9. Birthplace Dubnam, Iowa (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name Howard Starr
13. Birthplace Baltimore

MOTHER
14. Maiden Name Sebena Starr
15. Birthplace Baltimore

16 (a) Informant George F. Flentge, Jr.
(b) Address 1709 E. 32nd St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/9/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Greenmount
Location Greenmount & North Aves.

18 (a) Funeral director John C. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) NOV 8 1945 (Registrar's signature) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 6 1945, at 12.05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-11-1938, to 11-6-1945, and that I last saw her alive on 11-6-1945

Immediate cause of death	Duration
Arteriosclerotic cardio-renal disease	terminal
Due to	
Due to	
Other Condition Diabetes Mellitus	Contributory

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Geo. B. Sybert M. D.
Address 2802 Harford Road Date signed 11-7-45

VS 150

Sybert 131a

633976

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registration No. 633976

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5300 Reisterstown Rd.
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5302 Reisterstown Rd. (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Clara Vernon Ditch

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: wd dowed

6 (b) Name of husband or wife: Oscar Ditch
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 7, 1858

8. AGE: Years 87 | Months 8 | Days 29 | If less than one day ... hr. ... min.

9. Birthplace: Baltimore County, Md. (Town, county, and state)

10. Usual Occupation: housewife

11. Industry or business:

FATHER
12. Name: Joseph Feelemyer
13. Birthplace: Baltimore County, Md.

MOTHER
14. Maiden Name: Clarinda
15. Birthplace: Baltimore County, Md.

16 (a) Informant: Mrs. Whitney Bates
(b) Address: Temple Court Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/9/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Druid Ridge
Location: Pikesville, Md.

18 (a) Funeral director: John A. Mitchell & Sons, Inc.
(b) Address: 1900 Eutaw Place

19 (a) NOV 8 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 6, 1945, at 8.45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1. 1945 to Nov. 6 1945. and that I last saw her alive on Nov. 6 1945.

Immediate cause of death: Cerebral Hemorrhage — Duration: 8 hrs.
Due to: Cerebral and General Arteriosclerosis. — Duration: Unknown
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: James S. Akehurst M. D.
Address: 2012 Park Heights Ave. Date signed

akehurst X

G33977 D

Reg #96680

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161C

G33977

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 9 Days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 710 W. Fairmount Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Infant

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 15, 1945

8. AGE: Years	Months	Days	If less than one day
		9	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Earl Brown
13. Birthplace Penna.

MOTHER
14. Maiden Name Sarah Lewis
15. Birthplace Virginia

16 (a) Informant Balto. City Hospitals Records
(b) Address 4940 Eastern Avenue

17 (a) Cremated (Burial, cremation, or removal) (b) Date thereof 11-7-45 (month) (day) (year)
(c) Cemetery or crematory Baltimore City Hospitals
Location 4940 Eastern Ave

18 (a) Funeral director
(b) Address

19 (a) NOV 8 - 1945 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 24, 1945, at 2:30P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 15, 1945 to Oct. 24, 1945, and that I last saw him alive on Oct. 24, 1945

Immediate cause of death Sepsis — Duration 1 day

Due to Barragenes

Due to

Other Conditions Hemorrhage, uterus, type, undetermined
(Interval pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter M Tavern M. D.
Address Balt Date signed 11/8/45

Huntington Williams, M.D.

X

G33978

AB-96972

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G33978

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9min 12hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 220 N. Carlton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Chase

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 29-1945

8. AGE: Years	Months	Days	If less than one day
			12 hrs 9 min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name Dorothy Chase
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Cremated (b) Date thereof 11-2-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore City Hospitals
Location 4940 Eastern Ave

18 (a) Funeral director
(b) Address Huntington Williams, Md.

19 NOV 8 1945 (b)
(Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 30 1945, at 11.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-29 1945, to 10-30 1945, and that I last saw h 1m alive on 10-30- 1945

Immediate cause of death: Rupture pulmonary atelectasis — Duration 36 hrs.
Due to Pneumothorax
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature C. E. Sobel M. D.
Address B. C. H. Date signed 11-5-45

VS 150

G33979

HEP #96803

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G33979 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 Days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1204 Fayette St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Shroud or Shrout

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Infant

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 20, 1945

8. AGE: Years	Months	Days	If less than one day
		3	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Marvin Stevens
13. Birthplace Md.

MOTHER
14. Maiden Name Hilda Shroud or Shrout
15. Birthplace Md.

16 (a) Informant Balto. City Hospitals Records
(b) Address 4940 Eastern Avenue

17 (a) Cremated (b) Date thereof 11-7-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cremated Balto. City Hospitals
Location 4940 Eastern Ave

18 (a) Funeral director
(b) Address

19 NOV 8 - 1945 (c) Hunting for Williams, M.D.
(Signature of local registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 23, 1945, at 12:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 20, 1945, to Oct. 23, 1945, and that I last saw him alive on Oct. 23, 1945.

Immediate cause of death	Duration
Aspiration Pneumonia	
Due to Prematurity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D.T. Rees M.D.
Address BCH Date signed 11-13-45

D.T. Rees X

48300 G33980

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G33980

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 925 Wilmer Court (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Andrew Mitchell

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Ethel

6 (c) If alive, give age 28 years

7. Birth date of deceased (mo., day, yr.) 7-1-18

8. AGE: Years 27 | Months 4 | Days 4 | If less than one day hr. min.

9. Birthplace N. C (Town, county, and state)

10. Usual Occupation Truck Driver

11. Industry or business

FATHER | 12. Name Samuel Mitchell
13. Birthplace N. C.

MOTHER | 14. Maiden Name Nellie Warren
15. Birthplace N. C.

16 (a) Informant Rhonda
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-8-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION A.

20. DATE OF DEATH Nov - 5 1945 at 4.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov · 2 1945 to Nov · 5 1945 and that I last saw him alive on Nov · 5 1945

Immediate cause of death: Bronchopneumonia Pulmonary Edema — Duration

Due to uremia

Due to sulphonephthalein hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jolen S Green Jr

Address Johns Hopkins Hospital Date signed 11/6/45

VS 150

G33981

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 77c

G33981 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or Institution: Johns Hopkins Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dod
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1637 E. Fayette st (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ernest Bennett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1895

8. AGE: Years	Months	Days	If less than one day
50			hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Ernest Bennett Sr.
13. Birthplace Md

MOTHER
14. Maiden Name Sarah Porter
15. Birthplace Md.

16 (a) Informant Emanuel Lucas
(b) Address Central ave + Gaulbert

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/8/45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Broadway

19 (a) NOV 8 – 1945 (Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 4th 1945, at 2.10 P. M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Alcoholism

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed 11-5-45

Hunting for Nitrites

G33982

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G33982

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 423 So. Dallas Street
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 423 So. Dallas Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Katherine Pika

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) About 1885 ?

8. AGE: Years 60 ? | Months | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Grona
13. Birthplace Poland

MOTHER
14. Maiden Name Dorothy ? Unknown
15. Birthplace Poland

16 (a) Informant Mary Kowalewski
(b) Address 423 So. Dallas Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-10-45 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Baltimore, Md.

18 (a) Funeral director George A. Weber
(b) Address 705 So. Ann Street

19 (a) NOV 8 1945 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 7th 1945, at 7 10 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 20 1945 to Nov. 7 1945 and that I last saw h[illegible] alive on Nov 7 19 45.

Immediate cause of death
Pulmonary Edema
Arteriosclerosis
Degenerative

Duration
48h
years

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature George A. Lipsey M. D.
Address 423 S. Castleman St Date signed 11/8/45

VS 190

G33983 BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓108

G33983 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address No 5, N Schroeder St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days) 6 Months

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City Balto.
(c) City or town Balto Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5 - N. Schroeder St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Hodges Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Fem | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Louis Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 1, 1896

8. AGE: Years 49 | Months 7 | Days 6 | If less than one day hr. min.

9. Birthplace Ayden North Carolina
(Town, county, and state)

10. Usual Occupation Factory Worker.

11. Industry or business

FATHER
12. Name John L. Williams.
13. Birthplace Ayden N. C.

MOTHER
14. Maiden Name Edeth ?
15. Birthplace Ayden N. C.

16 (a) Informant Louis Smith.
(b) Address 881 W Fayette St.

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof Nov. 9 '45 (month) (day) (year)

(c) Cemetery or crematory
Location Durham N. C.

18 (a) Funeral director Mrs. Katie R. Williams.
(b) Address 2223 N. Schroeder St.

19 (a) (Date received by registrar) (b) Registrar

NOV 8 1945

vs lbo Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/7 1945 at 5P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 10 1945 to Nov 7 1945, and that I last saw her alive on Nov 7 1945

Immediate cause of death Dilatation of Heart — Duration

Due to Pulmonary Edema

Due to Pneumonia over

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? What at work? (Specify type of place)
(e) Means of injury

23. Signature Maurice Shideard M. D.
Address 2225 Linden Av Date signed

X 17

1 T 33984

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G33984

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2202 McCulloh St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2202 McCulloh St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cornelia Anthony White

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Widow

6 (b) Name of husband or wife William H.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 14, 1896

8. AGE: Years	Months	Days	If less than one day
76	8	21	hr. 18 min. 69

9. Birthplace N. Carolina
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Anthony Blunt
13. Birthplace N. C.

MOTHER
14. Maiden Name Lempy ?
15. Birthplace N. C.

16 (a) Informant Lillie White
(b) Address 2202 McCulloh St.

17 (a) Burial (b) Date thereof Nov. 9 '45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Park
Location Arbutus Md

18 (a) Funeral director Mrs. Robert O. Ellison Sr.
(b) Address 1129 N. Caroline St.

19 (a) Nov 9 1945 (b)
(Date rec'd by registrar) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-5-45 19 , at 7½ M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-2-45 19 , to 11-5-45 19 , and that I last saw h[illegible] alive on 11-4-45 19

Immediate cause of death	Duration
Hypertension Cardio Renal Disease	Unk Dys.
Due to	
Due to	
Other Conditions Diabetes Mellitus (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M Alvin Adams M. D.
Address 312 E 23rd St Date signed 11-7-45

X

G33985

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √186a

Registered No. G33985

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Give the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Md. Gen'l. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 80 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1208 N. Calvert St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARY W. LONG

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: Somerset Co., Md.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 5, 1861

8. AGE: Years 84 | Months 3 | Days 2 | If less than one day ... hr. ... min.

9. Birthplace: Somerset Co., Md. (Town, county, and state)
10. Usual Occupation: at home
11. Industry or business

FATHER
12. Name: Sydney C. Long
13. Birthplace: Somerset Co., Md.

MOTHER
14. Maiden Name: Mary Wilson
15. Birthplace: Va.

16 (a) Informant: Mr. Nivison Long
(b) Address: 1908 Cedric Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/9/45 (month) (day) (year)
(c) Cemetery or crematory: Greenmount Cem.
Location: Balto., Md.

18 (a) Funeral director: Wm. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) (Date rec'd by registrar) (b) Herrington Williams M.D. Registrar

NOV 8 - 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/7/ 1945, at 4:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/1 1945 to 11/7 1945, and that I last saw her alive on 11/6 1945.

Immediate cause of death: CEREBRAL HEMORRHAGE — Duration: 2m

Due to: HYPERTENSION — Duration: hospital 14 days

Due to: — Duration:

Other Conditions: FRACT. OF FEMUR AND RADIUS — Duration:
(Include pregnancy within 3 months of death)

Date of operation: NONE

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide: Accident.
(b) Date of occurrence: October 24th 1945 at A. M.
(c) Where did injury occur? 1208 N. Calvert Street (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home. (Specify type of place) While at work? No.
(e) Means of injury: Fell down stairs.

23. Signature: Charles W. Stewart, Jr. M. D.
Address: Md. Gen. Hosp. Date signed 11/7/45

For B. J. Lubinski, by Howard J. Meredith, M.D. X

G33986

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 181

G33986

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 807 S. Camp Meade Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Judith Clarke Callan

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: FEMALE | 5. Color or race: WHITE | 6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 11 - 1937

8. AGE: Years 8 | Months 13 | Days 27 | If less than one day hr. min.

9. Birthplace Johnstown Pennsylvania (Town, county, and state)

10. Usual Occupation School-Child.

11. Industry or business

FATHER
12. Name George H. Callan
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Rosemary Rice
15. Birthplace Pennsylvania

16 (a) Informant George Callan
(b) Address 807 S. Camp Meade Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 10 - 1945 (month) (day) (year)
(c) Cemetery or crematory St. Michaels
Location Loretta Pennsylvania

18 (a) Funeral director Burger Funeral Home
(b) Address 3631 Falls Road
(c) 1945 (Filed by registrar) Huntington Williams Md.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 8th 19 45, at 2 P. M

21. I certify that I took charge of the remains described above, held an Autopsy / Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
2nd and 3rd degree burns involving
Due to 28% of body surface.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11/2/45 at 7:45 P. M.
(b) Where did injury occur? 807 S. Camp Meade Rd
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Playing with matches.

23. Signature Benedict Sciarrio M.D. Medical Examiner.
Date signed 11-8-45

G33987

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1001 B2

Registered No. G33987

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) Past 8 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 419 S. Bond Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Fred B. Warner

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb. 6, 1893

8. AGE: Years 52 | Months 9 | Days — | If less than one day ____hr. ____min.

9. Birthplace Syracuse, N.Y. (Town, county, and state).
10. Usual Occupation Stationary Engineer
11. Industry or business Paul Jones Company

FATHER
12. Name Benjamin Albert Warner
13. Birthplace ?

MOTHER
14. Maiden Name Kitty Riley
15. Birthplace ?

16 (a) Informant Mrs. Lillie S. Watson
(b) Address 1118 Haverhill Rd. City, 29

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 9, 1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk
Location Catonsville

18 (a) Funeral director A. Howard Evans
(b) Address 1400 S. Charles St. City 30

19 NOV 8 - 1945 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 6, 1945, at 8:20 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary embolism, bilateral

Due to Thrombophlebitis, right leg.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ____ at ____ M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at (or) work?
(d) Means of injury

23. Signature Benedict Shtarelson Medical Examiner.
Date signed November 6, 1945.

G33988

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92c

G33988 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dead
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6428 Dogwood Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frank Wilkins

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-03-8393

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 18, 1892

8. AGE: Years	Months	Days	If less than one day
53	5	20	hr. min.

9. Birthplace Wilton, Maine (Town, county, and state)

10. Usual Occupation Burner

11. Industry or business Balmar Corporation

FATHER
12. Name George W. Blackmar
13. Birthplace United States

MOTHER
14. Maiden Name Helen M. Hall
15. Birthplace United States

16 (a) Informant Mrs. Anna Duff
(b) Address 6428 Dogwood Road, Woodlawn

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 10, 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. View Cemetery
Location Howard County, Md.

18 (a) Funeral director E. Hillis Lamoreaux
(b) Address 4510 Liberty Heights Ave.

19 (a) NOV. 8 - 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 8 1945, at 8 A. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to Live death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Rheumatic Endocarditis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Bratton M.D. Medical Examiner.
Date signed Nov. 8 1945

G33989

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G33989

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 52 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2163 Hollins St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE T. SIMMONS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Emma M. Simmons

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 20, 1874

8. AGE: Years 71 70 | Months 9 | Days 18 | If less than one day ..... hr. ..... min.

9. Birthplace Millington, Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Real Estate - Clerk

FATHER
12. Name Mr. Simmons
13. Birthplace United States

MOTHER
14. Maiden Name Unknown
15. Birthplace United States

16 (a) Informant Mrs. Harold Aaron
(b) Address 2163 Hollins St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 10, 1945 (month) (day) (year)
(c) Cemetery or crematory Western Cemetery
Location Baltimore, Md.

18 (a) Funeral director Willis Lawrence
(b) Address 1003 W. Baltimore St.

19 (a) 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/8 1945, at 7.15 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage, spontaneous

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Nov 8 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G33990

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G33990

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1537 N Bentalou St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-3
(e) Length of stay in Baltimore (yrs., mos., or days) 46 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1537 N Bentalou St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie Wasserman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Late Solomon
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1867

8. AGE: Years 78 | Months | Days | If less than one day hr. min.

9. Birthplace: Bruabla
(Town, county, and state)

10. Usual Occupation

11. Industry or business: House Work

FATHER
12. Name: Eli Rosenswog
13. Birthplace: Russia

MOTHER
14. Maiden Name: Dena ?
15. Birthplace: Russia

16 (a) Informant: Samuel Wasserman
(b) Address: 1537 N Bentalou St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Nov, 9, 1945 (month) (day) (year)
(c) Cemetery or crematory: Hebrew Rosedale Cem
Location: Hamilton Ave

18 (a) Funeral director: Sol Levinson & Bros
(b) Address: 1124-1126 W North Ave

NOV 9 - 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION 7.35

20. DATE OF DEATH November 8 1945, at A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 11 1940 to Nov. 8 1945, and that I last saw h.e alive on Nov 7, 1945.

Immediate cause of death: Coronary Thrombosis — Duration: 4 days
Due to: Hypertensive Cardio-Vascular Renal Disease
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:
23. Signature: Samuel Wolfe M.D.
Address: 1331 Eutaw Ave Date signed 11-8-45

VS 150

X

G33991

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 B

Registered No. G33991

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2157 Mt. Holly St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 d
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2157 Mt. Holly St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARY E. JOLLY

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Joshua R. Jolly
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 3, 1866

8. AGE: Years	Months	Days	If less than one day
79	5	5	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Geo. Washington Collins
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Mary E. Lewis
15. Birthplace Ellicott City, Md.

16 (a) Informant Mrs. Wm. H. Jolly
(b) Address 4119 Hamilton Ave.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof Nov. 10, 1945 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Balto., Md.

18 (a) Funeral director Lorsch Funeral Home
(b) Address 7401 Belair Road

19 (a) Nov 9 1945 (Date received by Registrar) (b) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 8th 1945, at 11 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 31 1945, to Nov 8 1946, and that I last saw her alive on Nov 7 1946.

Immediate cause of death	Duration
Edema of Lungs	1 day
Due to Mitral Stenosis	5 yrs
Due to Arterio Sclerosis	8 yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. Bill Hall
Address 1631 E. North Av Date signed 11/9/45 M. D.

VS 150

G33992

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G33992 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 12 E. 25th. street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 4 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Worcester
(c) City or town Snow Hill
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louise A. Covington

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
About 79			hr. min.

9. Birthplace Snow Hill, Md. (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name George W. Covington
13. Birthplace Berlin, Md.

MOTHER
14. Maiden Name Sally Bishop
15. Birthplace Snow Hill, Md.

16 (a) Informant Mrs. H. F. Covington
(b) Address Snow Hill, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/11/45 (month) (day) (year)
(c) Cemetery or crematory Makemie Memorial Presbyterian
Location Snow Hill, Md.

18 (a) Funeral director H. W. Messick Son.
(b) Address 805 N. Calvert street

NOV 9 1945 (Date received by Registrar) Huntington Williams M.D. (Registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 8 1945, at 9.30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 10 1920, to Nov 8 1945, and that I last saw her alive on Nov. 8 1945.

Immediate cause of death Coronary occlusion — Duration
Due to arteriosclerosis and hypertension
Due to
Other Conditions Diabetes mellitus
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature John A Luetscher M. D.
Address 1 Eleanor St Date signed 11/9/45

Luetscher 94a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G33993

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 131a

G33993 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 148 N Lumford Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 148 N Lumford Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Georganna E Johnson

3 (b) If veteran, name war —
3 (c) Social Security Account No. none

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Thomas M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 28, 1876

8. AGE: Years 69 | Months — | Days 10 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name George Green
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Margaret Riley
15. Birthplace Baltimore Md

16 (a) Informant Thomas M Johnson
(b) Address 148 N Lumford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 12 45 (month) (day) (year)
(c) Cemetery or crematory Woodland Cem
Location Baltimore Co Md

18 (a) Funeral director Thomas & Dee
(b) Address 1217 E Cold St

19 (a) (Date rec'd by registrar) NOV 9 - 1945 (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 8 1945, at 4:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 10 1945 to Nov 8 1945, and that I last saw h[illegible] alive on Nov 7 1945.

Immediate cause of death	Duration
Chronic Myocarditis	
Due to Hypertensive Cardiovascular Renal Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel B Wolfe M. D.
Address 1331 E Northwood Date signed 11-8-45.

X

G33994

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G33994

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mount Hope Retreat
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 9 days

2. USUAL RESIDENCE OF DECEASED:
(a) State N. J. (b) County
(c) City or town Vineland (If outside city or town limits, write RURAL and give town)
(d) Street No. 402 Beech Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Paul Aloysius Doerr

3 (b) If veteran, name war

3 (c) Social Security Account No. 144-10-4508

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Louise M. Doerr

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 4 1909

8. AGE: Years 36 | Months 10 | Days 7 | If less than one day hr. min.

9. Birthplace Philadelphia Pa. (Town, county, and state)

10. Usual Occupation Shipper

11. Industry or business

FATHER: 12. Name Herman R. Doerr
13. Birthplace Alsace, Lorraine, Germany

MOTHER: 14. Maiden Name Catharine A. M. Lynch
15. Birthplace Chestnut Hill Philadelphia Pa.

16 (a) Informant Mount Hope Retreat
(b) Address 6420 Reisterstown Rd. Balto Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-12-1945 (month) (day) (year)
(c) Cemetery or crematory Most Holy Redeemer (Bridesburg)
Location Phila. Penna.

18 (a) Funeral director Stewart and Mowen Company
(b) Address 108 W. North Ave. Balto. Md.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

NOV 9 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH November 8 1945, at 1.50 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 31 1945, to Nov. 8 1945, and that I last saw him alive on Nov. 8 1945

	Duration
Immediate cause of death: Acute Cardiac Vascular collapse	2 days
Due to	
Due to	
Other Conditions: Post Infectious psychosis following amputation of rt. thigh (Include pregnancy within 3 months of death)	19 days

Date of operation Oct. 20, 1945 Autopsy? No
Major findings of operation: Stump infection
of autopsy: gangrene

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Damian P. Kelly M. D.
Address 336 Madison St. Date signed

G33995

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G33995 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eutaw Place & Wilson St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 1
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Marlborough Apts.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME BERTHA MEYENBERG.

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: FEMALE
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: SINGLE

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 3, 1867.

8. AGE: Years 78 | Months 10 | Days 5 | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Wolf Meyenberg,
13. Birthplace Germany.

MOTHER
14. Maiden Name Sarah Bernheimer,
15. Birthplace Conn.

16 (a) Informant Mrs. A. Roller,
(b) Address Marlborough Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11.9.45. (month) (day) (year)
(c) Cemetery or crematory Oheb Shalom
Location Balto. Md.

18 (a) Funeral director Christ Lomasney & Sons
(b) Address 1902 Eutaw Place.

19 (a) (Date received by registrar) NOV 9 1945 (b) Huntington Williams, M.D. Registrar

VS 150 . 2

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 8th. 1945, at 1.25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sep. 1 1944 to 11-8 1945 and that I last saw h. alive on 11-8 1945

Immediate cause of death: acute Coronary Thrombosis — Duration: 2 hrs
Due to: Hypertension — Duration: years
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dr. Benenson
Address Marlborough Apts. Date signed 11/9/45 M. D.

G33996

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G33996 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Wilkins & Cator Aves

(c) Hospital or institution:

St. Agnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 25

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 3901 Eighth Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Susan R. Murrell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 9 1869

8. AGE: Years	Months	Days	If less than one day
76	7	-	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name John

13. Birthplace Maryland

MOTHER 14. Maiden Name Susan Simms

15. Birthplace Maryland

16 (a) Informant Daughter Helen Robbins

(b) Address 3901 Eighth Ave.

17 (a) ~~Burial~~ Burial (b) Date thereof 11/12/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Location Cambridge, Md.

18 (a) Funeral director John B. Mitchell & Sons

(b) Address 1900 Eutaw Pl.

19 (a) NOV 9 1945 Huntington Williams, M.D. Registrar
(Local registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/9 1945 at 2:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/24 1945 to 11/9 1945 and that I last saw her alive on 11/9 1945.

Immediate cause of death Cardiac failure

(a) Pneumonia, lobar

Due to

Due to Generalized Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature L. H. D. Elias M. D.

Address St. Agnes Hosp. Date signed 11/9/45

633997

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 557

633997 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2736 Winchester St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2736 Winchester St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM W. ARMESWORTHY

3 (b) If veteran, name war: none
3 (c) Social Security Account No. 213-03-0649

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Margaret S. Armesworthy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 2, 1894

8. AGE: Years	Months	Days	If less than one day
51	2	5	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Accountant
11. Industry or business Allied Paper Bag Co.

FATHER
12. Name Daniel W. Armesworthy
13. Birthplace Md.

MOTHER
14. Maiden Name Laura Kiester
15. Birthplace Md.

16 (a) Informant Mrs. Margaret S. Armesworthy
(b) Address 2736 Winchester St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/10/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 9 - 1945 (Date received by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 7, 1945, at 2:40 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 11-5 1945 to 11-7 1945, and that I last saw h[illegible] alive on 11-7 1945

Immediate cause of death: Carcinoma of Maxillary Sinus — Duration 2 yrs.
Due to
Due to
Other Conditions None
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

Signature Leon Ackerman M. D.
Address 1201 Pyfed Ames St Date signed 11-8-45

VS 150

G33998

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1579

G33998 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Madison & Broadway
(c) Hospital or institution: Md. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 days
(e) Length of stay in Baltimore (yrs., mos., or days) 24 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Arbutus
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5532 Lenk Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Wagner (Baby Jean Louise Wagner)

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife:
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct 14/1945
8. AGE: Years | Months | Days: 24 | If less than one day: hr. min.
9. Birthplace: Baltimore Md. (Town, county, and state)
10. Usual Occupation: None
11. Industry or business:

FATHER
12. Name: Robert O. Wagner
13. Birthplace: Phila. Pa.

MOTHER
14. Maiden Name: Mary E. McGowan
15. Birthplace: Mt. Airy, Md

16 (a) Informant: Mr Robt. O. Wagner
(b) Address: Arbutus Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 10, 1945 (month) (day) (year)
(c) Cemetery or crematory: London Park
Location: London Park

18 (a) Funeral director: Wm. J. Tickner & Sons
(b) Address: North & Pa. Aves.

19 (a) (Date received by Registrar) NOV 9 1945 (b) Registrar: Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 8, 1945 at 8:47 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-7 1945 to 11-8 1945 and that I last saw her alive on 11-8 1945

Immediate cause of death	Duration
Terminal bronchopneumonia	
Due to Anoxia	
Due to Interstitial Atelectasis	
Other Conditions Cleft palate	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: O. M. Cowell M. D.
Address: Md. Gen. Hosp. Date signed 11-8-45

B.C. - G35145 - Youngblood

G33999

BALTIMORE CITY HEALTH DEPARTMENT ✓

CERTIFICATE OF DEATH 119a

G33999 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp. 9a
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 12 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. 18 (If outside city or town limits, write RURAL and give town)
(d) Street No. 3807 Yolanda Rd. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Sally Ann Bauman ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 27, 1945

8. AGE: Years	Months	Days	If less than one day
		12	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name Norman Bauman
13. Birthplace Carroll County, Md.

MOTHER
14. Maiden Name Melba Holtzman
15. Birthplace Balto

16 (a) Informant Norman Bauman
(b) Address 3807 Yolanda Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/10/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 9 - 1945 (Registered by registrar) (b) Huntington for Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/9 1945, at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/8 1945, to 11/9 1945, and that I last saw her alive on 11/9 1945.

Immediate cause of death Circulatory Collapse — Duration

Due to Dehydration

Due to Diarrhea

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles Stuhen D
Address Mercy Hosp Date signed 11/9/45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34000

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G34000 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dukeland & Ramsay
(c) Hospital or institution:
West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2½ hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Rodgers Forge
(If outside city or town limits, write RURAL and give town)
(d) Street No. 421 Dunloek Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John A Wilson
3 (b) If veteran, name war
3 (c) Social Security Account No. 217-09-2460
4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced. Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 4/29/1902
8. AGE: Years 43 Months 6 Days 9 If less than one day hr. min.
9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Meyers Clerk
11. Industry or business Raw Stock

FATHER
12. Name John C Wilson
13. Birthplace Baltimore

MOTHER
14. Maiden Name Anna M Detering
15. Birthplace Baltimore

16 (a) Informant Mrs L. J. Shannon
(b) Address 421 Dunloek Rd

17 (a) Burial (b) Date thereof 11/10/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd & Hollins Ferry Rd

18 (a) Funeral director J. Pickney Love
(b) Address 2218 Light St

19 (a) NOV 9 - 1945 By Hunting for Williams, Mgr
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/7 1945, at 1:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/7 1945 to 11/7 1945, and that I last saw him alive on 11/7 1945.

Immediate cause of death Cardiac failure and Chronic Alcoholism

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Philip F. Lerner
Address 2401 N. North Ave Date signed 11/9/45

X

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634001

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 634001

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1 of Paraphernalia
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1 of Paraphernalia
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Frances Payne

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	Widow

6 (b) Name of husband or wife: John W. Payne — 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Not Known

8. AGE: Years	Months	Days	If less than one day
abt 82	-	-	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name Wm. St. Morgan
13. Birthplace Md

MOTHER
14. Maiden Name Mary Rosamond
15. Birthplace Md

16 (a) Informant Mrs R. Payne
(b) Address 1 of Paraphernalia

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/15/45 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Ritchie Highway

18 (a) Funeral director D. J. Daley & Sons
(b) Address 1318 Light St

19 (a) NOV 9 (Date rec'd by registrar) (b) 1945 Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 7 1945, at M

21. I certify that death occurred on the date above stated: that I attended deceased from Oct 15 1945 to Nov 7 1945, and that I last saw h[er] alive on Nov 6 1945.

Immediate cause of death	Duration
Myocardial Insufficiency	
Due to	
Due to	
Other Conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John C. Schwenck M. D.
Address 1337 S Charles St Date signed 11/5/45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34002

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 462

Registered No. G34002

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1720 McKean Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1720 McKean Ave.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry A. Strong

3 (b) If veteran, name war --

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Hattie I. Strong
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 26, 1880

8. AGE: Years 65 | Months 4 | Days 12 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name George W. Strong
13. Birthplace Baltimore Co., Md.

MOTHER
14. Maiden Name Emma K. Towson
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Hattie I. Strong
(b) Address 1720 McKean Ave.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-10-45 (month) (day) (year)
(c) Cemetery or crematory xx Loudon Park
Location Baltimore, Md.

18 (a) Funeral director D. Howard Strong
(b) Address 3207 W. North Ave.

NOV 9 - 1945 (b) Date rec'd by Registrar

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 7, 1945, at 11.15 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1945 to Nov 7 1945 and that I last saw him alive on Nov. 7 1945

Immediate cause of death Carcinoma of Stomach — Duration unknown

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry Colman M.D.

Address 1921 W. North Ave. Date signed Nov 9 1945 M. D.

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34003

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G34003

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2318 Allendale Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 38yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2318 Allendale Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Morris Morris Schloss

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-01-8093

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Esther

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years	Months	Days	If less than one day
60			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business

FATHER
12. Name Aaron Schloss
13. Birthplace Russia

MOTHER
14. Maiden Name Ida Schloss
15. Birthplace Russia

16 (a) Informant Mrs. Esther Schloss
(b) Address 2318 Allendale Road

17 (a) Burial (b) Date thereof 11-9-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Balto. St

19 (a) Nov 9 - 1945 Huntington Williams
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-8-45 19 , at 10 1/2 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1st 1945 to Nov 8 1945 and that I last saw him alive on Nov 7 1945

Immediate cause of death	Duration
Acute pulmonary Edema	1 day
Due to Myocardial infarct: Coronary Thrombosis	Oct 1/45
Due to Generalized arteriosclerosis with Arterial heart dys. 5 yrs. symptoms	1939
Other Conditions Hypertension 5 yrs. symptoms	1939

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis P. Hamburger M. D.
Address 1207 Eutaw Pl Date signed Nov 8 1945

VS 150

G34004

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

JL- 16122

G34004 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12- 2 - 17
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore No House
(If outside city or town limits, write RURAL and give town)
(d) Street No. Rosedale Ave. & Bridge
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mamie Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Frederick
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 15, 1883

8. AGE: Years	Months	Days	If less than one day
62 61	7	24	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Samuel Smith
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary Dillihunt
15. Birthplace Baltimore

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/10/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Milton Ave & Rose Hill

18 (a) Funeral director Howard N. Blight, Jr.
(b) Address 4914 Belair Road

19 (a) NOV 9 1945 (Registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 8, 1945 19 at 9.05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 22 1932, to Nov. 8 1945, and that I last saw h er alive on Nov. 8 1945

Immediate cause of death	Duration
Coronary thrombosis	
Due to arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: none
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature T. P. Jernigan
Address Baltimore City Hosp. Date signed 11-9-45 M. D.

G34005

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G34005

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1409 E. Lafayette Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1409 E. Lafayette Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Edwin Kirwan

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 215-05-5657

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife: Lula Mae Fowler
6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) July 31, 1898

8. AGE: Years	Months	Days	If less than one day
47	3	7	######## min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name John Edwin Kirwan
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Dora Mae Stehn
15. Birthplace Germany

16 (a) Informant Mrs. Lula Mae Kirwan, Wife
(b) Address 1409 E. Lafayette Avenue

17 (a) Burial (b) Date thereof 11/10/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Meadowridge
Location Washington Blvd. Howard Co. Md

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 NOV 9 - 1945 (b) Huntington Mills
(Date rec'd by Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/7 1945 at 3:24 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. P. Sabrinsky M.D.
Medical Examiner.
Date signed 11/15/45

G34006

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G34006 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3229 Fait Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) Died
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 3229 Fait Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Stanislaus Ryckwalski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	widowed

6 (b) Name of husband or wife Barbara

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1861

8. AGE: Years	Months	Days	If less than one day
84			hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Andrew Ryckwalski
(b) Address 1116 S Robinson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/10/45 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Dundalk Ave

18 (a) Funeral director John J. Duda
(b) Address 2829 Hudson St

19 NOV 9 - 1945 (Date rec'd by registrar) (b) Huntington for Williams, M. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/7 1945 at 7:30 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Hypertensive - Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D. Medical Examiner.
Date signed 11/7/45

G34007

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G34007

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.D.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 410 N. Pulaski St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John J. Stoker Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Katherine H. Stoker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 19th 1906

8. AGE: Years	Months	Days	If less than one day
39	7	19	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Nickel Plater.
11. Industry or business

FATHER
12. Name John J. Stoker Sr.
13. Birthplace New York

MOTHER
14. Maiden Name Marie Schilling.
15. Birthplace Germany

16 (a) Informant Katherine H. Stoker
(b) Address 410 N. Pulaski St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 10/1945 (month) (day) (year)
(c) Cemetery or crematory Western Cemetary
Location Edmondson Ave. Balto. Md.
18 (a) Funeral director George Weber & Son.
(b) Address 2503 Edmondson Ave.
19 (a) (b) Huntington Williamson, M.D.

NOV 9 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH November 8 1945, at 8:50 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Gastman M.D. (Medical Examiner.)
Date signed 11-8-45

X

G34008 482838

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G34008 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 229 Bethel Court.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian Nelson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-8-80

8. AGE: Years	Months	Days	If less than one day
65	2	28	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Simpson
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Murray
15. Birthplace Md.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 11-10-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvery
Location

18 (a) Funeral director Elroy S. Wilson
(b) Address 1000 Brantley Ave

19 (a) NOV 9 - 1945 (b) Received by Huntington Williams Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 6. 1945 at 2. A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 30 1945 to Nov. 6 1945 and that I last saw him alive on Nov. 6. 1945.

Immediate Cause of death: Respiratory failure
Due to: Pneumonia R L + L L.
Due to: Pneumococcus
Due to: Hypertension and Arteriosclerotic heart disease
Other Conditions: Cardiac failure

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William T. Dorsey
Address Johns Hopkins Hospital Date signed 11/6/45

G34009

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G34009

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 9 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1713 W. Lexington St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Isaac Byrd Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-25-45

8. AGE: Years	Months	Days	If less than one day
		9	hr. min.

9. Birthplace Buels. md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joseph Isaac Byrd
13. Birthplace Buels. md.

MOTHER
14. Maiden Name Annetta Lucas
15. Birthplace Durham N.C.

16 (a) Informant Annetta Byrd
(b) Address 1713 W. Lexington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 9 1945 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St
(c) NOV 9 - 1945 (Date rec'd by registrar) Huntington Williams Mortuary

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 - 2 1945; at 9 25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-25 1945, to 11-2 1945, and that I last saw him alive on 11-2-1945.

Immediate cause of death Premature Birth — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. W. Reckling M.D.

Address 426 N. Gilmor St. Date signed 11/3/45

G34010

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G34010

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) ABOVE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 211 N. Lakewood Ave. (If rural give location)
(e) Citizen of foreign country? Naturalized (Yes or No) If so, name country

3 (a) FULL NAME James Otis Stumpf

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Anna Stumpf

6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) Oct 25. 1879

8. AGE: Years	Months	Days	If less than one day
66	—	14	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Brick Layer

11. Industry or business

FATHER
12. Name James Otis
13. Birthplace Baltimore

MOTHER
14. Maiden Name Margaret Repp
15. Birthplace Baltimore

16 (a) Informant Mrs Anna Stumpf
(b) Address 211 N Lakewood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 12 (month) (day) (year)
(c) Cemetery or crematory Trinity Cemetery
Location City

18 (a) Funeral director Sellers Funeral Home
(b) Address 2008 Orleans St

19 (a) (Date received by Registrar) NOV 9 - 1945 (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 8 1945; at 10:45 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at A.M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skotarlis M.D. Medical Examiner.
Date signed 11-9-45

G34011

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 119a

G34011 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 No. Caroline St.
(c) Hospital or institution: Saint Joseph Hospital 20
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) 25 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Balto
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 23 No. Clinton St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME XENAKIS (BABY GIRL)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 15 1945

8. AGE: Years	Months	Days	If less than one day
		25	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER 12. Name Mathews X-naleis
13. Birthplace Greece

MOTHER 14. Maiden Name Ethel Takas
15. Birthplace Greece

16 (a) Informant Helen Kasiotis
(b) Address 331 E Baltimore St

17 (a) Burial (b) Date thereof Nov 10 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greek Ch
Location Woodlawn

18 (a) Funeral director John A. Moran
(b) Address 3600 Baltimore St

19 (a) NOV 10 1945 Huntington Williams MD
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-9-1945; at 2.35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-25-1945, to 11-9-1945, and that I last saw h alive on 11-9-1945.

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Dehydration and toxemia	
Due to Diarrhea and pneumonia	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature Harry T Wilson Jr
Address St Joseph's Hosp Balto Date signed 9/Nov/45

VS 150

G34012

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G34012

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1014 N. Lanvale St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 59

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1014 N. Lanvale St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Jennie Theresa Bowen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 7, 1870

8. AGE: Years 75 | Months 6 | Days 0 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housekeeper

11. Industry or business

FATHER
12. Name Josiah Bowen
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Ann Maria ?
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Marie Hillen
(b) Address 1014 N. Lanvale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 10, 1945 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director Mrs. Laura A. Stallard
(b) Address 1631 Druid Hill Ave.

NOV 10 1945 (b) Huntington Williams, M.D. Registrar
(Date received by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-7- 1945, at 11:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 15, 1945 to Nov. 7, 1945 and that I last saw her alive on Nov. 2, 1945.

Immediate cause of death	Duration
Cerebral accident	
Due to Arteriosclerosis with hypertension	
Due to	
Other Conditions Chronic myocarditis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature O. R. Campbell M. D.
Address 718 Dolphin St. Date signed 11-9-45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34013

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G34013 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1707 Woodyear Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 D
(e) Length of stay in Baltimore (yrs., mos., or days) 75

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1707 Woodyear Ave (If rural, give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Estelle Diggs (DIGGS)

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Joseph

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 31, 1886

8. AGE: Years 59 | Months — | Days 7 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Robert Elliott
13. Birthplace Maryland

MOTHER
14. Maiden Name Jennie Cromwell
15. Birthplace Cambridge, Md.

16 (a) Informant Joseph Diggs
(b) Address 1707 Woodyear Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 11, 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion
Location Baltimore, Md.

18 (a) Funeral director Wm. George W. Hyland
(b) Address 1631 Druid Hill Ave.

19 (a) NOV 10 1945 (Date rec'd by registrar) (b) Registered Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 7 1945 at. 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 2 1945 to Nov 7 1945 and that I last saw him alive on Nov 7, 1945

	Duration
Immediate cause of death: Cerebral hemorrhage	6 wks
Due to: Arteriosclerosis	7 yrs
Due to:	
Other Conditions: Diabetes mellitus	15 yrs

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John E. L. Campbell M. D.
Address 639 N. Carey St Date signed 11-9-45

VS 150

83a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34014

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G34014

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5-2
(e) Length of stay in Baltimore (yrs., mos., or days) DA

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 510 North Jay Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM HORAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1861

8. AGE: Years 84 | Months | Days | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Paper Hanger

11. Industry or business

FATHER
12. Name William J Horan
13. Birthplace unknown

MOTHER
14. Maiden Name Sophia Wiler
15. Birthplace unknown

16 (a) Informant Mrs Arthur Leaf Cousin
(b) Address 1632 N Caroline St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/10/40 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location E North ave

18 (a) Funeral director Geo J Ruth Inc
(b) Address 1330 Harford ave

19 (a) (Date filed by registrar) (b) Huntington Nolle Register M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/8/40 19 ..., at 5:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Davis M.D. Medical Examiner.
Date signed 11/9/40

VS 151

G34015

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

101

G34015 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. Belair Rd & Slade Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carroll N. Abruich

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/24/45

8. AGE: Years	Months	Days	If less than one day
	8	15	hr. min.

9. Birthplace Balto. Co. Md (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name Peter P. Abruich
13. Birthplace Balto. Co. Md.

MOTHER
14. Maiden Name Evelyn E. Lancaster
15. Birthplace Balto. Co. Md.

16 (a) Informant P P Abruich
(b) Address Belair Rd & Slade Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/12/45 (month) (day) (year)
(c) Cemetery or crematory H. Michaelsville
Location Balto. Co. Md.

18 (a) Funeral director Lazaha Funeral Home
(b) Address 7401 Belair Rd.

19 (a) (Date received by Registrar) (b)

NOV 10 1945

Registrar

VS 151

MEDICAL CERTIFICATION 13105

20. DATE OF DEATH November 9, 1945, at 12 M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Edema.

Due to Upper Respiratory Infection,

Other Conditions Mesenteric lymphadenitis.
(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Petrelis M.D.
Medical Examiner.
Date signed November 9, 1945.

G34016

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 178a

Registered No. G34016

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) d. o. a.
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 515 S. Patterson Park Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Scott

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.: NONE

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Henry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUNE 19 1863

8. AGE: Years: 82 | Months: 4 | Days: 20 | If less than one day: hr. min.

9. Birthplace: Va. - Md.
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business: At home

FATHER
12. Name: ?
13. Birthplace: ?

MOTHER
14. Maiden Name: ?
15. Birthplace: ?

16 (a) Informant: G. Pierce - (Grandson)
(b) Address: 7103 BRISTOL ROAD

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/12/45 (month) (day) (year)
(c) Cemetery or crematory: Oak Lawn
Location: Oak Ave. Col.

18 (a) Funeral director: Selby & Peach Sr.
(b) Address: 1443 S. Monroe St.

19 NOV 10 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 9, 1945, at 9:30 P. M.

21. I certify that I took charge of the remains described above, held an Inspection + Inquiry Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Asphyxiation —

Due to: Carbon Monoxide

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-8-45 at P. 1/3 M.
(b) Where did injury occur? 515 S. Patterson Park Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Home. While at work? No.
(d) Means of injury: Gas escaped from jets on 2 burner gas range.

23. Signature: Robert A. Faehn M.D. Medical Examiner.
Date signed November 9, 1945.

G34017

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

Registered No. G34017

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1107 S.BOULDIN ST.
(c) Hospital or institution:
26
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 YEARS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1107 S.BOULDIN ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: EDWARD HALE

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of husband or wife ANNIE HALE
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JAN.16 1877

8. AGE: Years	Months	Days	If less than one day
68	9	24	hr. min.

9. Birthplace YORK PA.
(Town, county, and state)
10. Usual Occupation JANITOR
11. Industry or business COPPER WORKS

FATHER
12. Name CHARLES HALE
13. Birthplace PA.

MOTHER
14. Maiden Name JENNIE ?
15. Birthplace PA.

16 (a) Informant ANNIE HALE (WIFE)
(b) Address 1107 S.BOULDIN ST.

17 (a) BURIAL (b) Date thereof NOV.14/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory SACRED HEART
Location GERMAN HILL ROAD
18 (a) Funeral director Tilly & Zeiler inc.
(b) Address 403 S.WOLFE ST.
NOV 10 1945 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION AM.

20. DATE OF DEATH NOV. 9 1945 at 7/30M
21. I certify that death occurred on the date above stated; that I attended deceased from NOV 1 1945 to NOV 9 1945, and that I last saw h[illegible] alive on NOV 8 1945

Immediate cause of death	Duration
Cor. Thrombosis	6 days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature A. J. Sealman M.D.
Address 3500 Sinai Date signed 11/9/45

VS 150

X

G34018

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1944a

Registered No. G34018

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1014 N Central Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1014 N Central Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nicholas Phelan

3 (b) If veteran, name war: Spanish
3 (c) Social Security Account No.:
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Mary Phelan
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Feb 1876
8. AGE: Years 69 Months 9 Days If less than one day hr. min.
9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Painter Retired
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mary Phelan
(b) Address 1014 N Central Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/13/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ U. S. National
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1211 E. Fort St

19 (a) NOV 10 1945 (Signature of registrar)

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 9 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/9 1945 to 11/9 1945 and that I last saw h... alive on 11/9 1945.

Immediate cause of death: Coronary Thrombosis
Acute Pulmonary Edema
Duration: 2 hours

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sol Smith
Address 1223 E. North Ave Date signed M. 11 D. 9/45

Benedict Skotarelis M. D. X

G34019

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G34019 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 810 Burgundy St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 810 Burgundy St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carrie King

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or Robert C. King
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 22nd 1869

8. AGE: Years	Months	Days	If less than one day
76	3	15	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Own Home

FATHER
12. Name Harry Zimmell
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Koch
15. Birthplace Germany

16 (a) Informant Mrs Thelma Styles
(b) Address 905 S. Paca St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/10/45 (month) (day) (year)
(c) Cemetery or crematory Western
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) (Signature of registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 7th 1945, at 3 30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/10 1944 to 11-7 1945 and that I last saw h. alive on 11/7 1945.

Immediate cause of death	Duration
Acute Cardiac Failure	1 da
Due to Chronic Myocarditis	1 yr
Adenoma of Breast	
Due to C metastasis	1 yr
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Joseph G Lanteri
Address 1716 Washington Blvd Date signed 11/9/45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34020

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

G34020 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Fallsway & Eaton Ave

(c) Hospital or institution: St. Agnes Hospital 2019

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1 So. Culver St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Clarence L. Preseaker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Teresa

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 24 - 1897

8. AGE: Years	Months	Days	If less than one day
47	3	16	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Fireman

11. Industry or business Western Md Dairy

FATHER

12. Name Henry Orpeschew

13. Birthplace Germany

MOTHER

14. Maiden Name Mary Mayer

15. Birthplace Germany

16 (a) Informant Wife Teresa Orpeschew

(b) Address 1 So. Culver St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/12/45 (month, day, year)

(c) Cemetery or crematory Loudon Park

Location Baltimore, Md

18 (a) Funeral director F. D. Hilgenberg & Son

(b) Address 651 W. Baltimore St

19 (a) NOV 10 1945 (Date received by Local Registrar) Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/9 1945, at 8:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/31 1945 to 11/9 1945; and that I last saw h[illegible] alive on 11/9 1945.

Immediate cause of death	Duration
Uremia	
Due to Chronic Glomerulo nephritis	
Due to	
Other Conditions Hypertension	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Chas. Roeckle, Jr. M.D.

Address St. Agnes Hosp. Date signed 11/9/45

PHYSICIAN

Underline the cause to which death should be charged statistically.

G34021 — BALTIMORE CITY HEALTH DEPARTMENT — G34021

CERTIFICATE OF DEATH

Registered No. 1242

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5311 Brady Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) No
If yes, name country

3 (a) FULL NAME Earle L. Montgomery

3 (b) Veteran of what war: World I-2
3 (c) Social Security Account No. 218-03-9667

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced:
6 (b) Name of husband or wife: Celia
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): April 15 1899

8. AGE: Years 46 | Months 6 | Days 23 | If less than one day ..... hr. ..... min.

9. Birthplace: Baltimore (Town, county and state)
10. Usual Occupation: Clerk
11. Industry or business:

FATHER
12. Name: Edward A. Montgomery
13. Birthplace: Balto. Md.

MOTHER
14. Maiden Name: Mary E. Langley
15. Birthplace: Balto. Md.

16 (a) Informant: Mary E. Montgomery
(b) Address: 330 Hillen Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Nov 12-45 (month) (day) (year)
(c) Cemetery or crematory: Balto. Comm.
Location: E. North Ave.

18 (a) Funeral director: Jas. L. Hagan
(b) Address: 800 E. Balto. St.

19 (a) (b)
NOV 10 1945 (Date received in office) Registrar: Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 8 - 1945, at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 6 1945 to Nov 8 1945 and that I last saw him alive on Nov 8 1945

Immediate cause of death: Gastric Hemorrhage — Duration
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: Thos. E. Wheeler
Address: South Balto Gen Hosp. Date signed: 11/8/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3 13 188
634022

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 55E

Registered 634022

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2118 N. Charles St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jennie Pugh
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-22-90

8. AGE: Years 49 | Months 7 | Days 17 | If less than one day: hr. min. 1896

9. Birthplace Indiana (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Alec Jones -
13. Birthplace Ky -

MOTHER
14. Maiden Name Catherine Phillips
15. Birthplace Ky -

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof NOV 11 45 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Greenmount Baltimore

18 (a) Funeral director Oden Funeral Home Inc
(b) Address 4684 York Rd

19 (a) NOV 10 1945 (Date received by Registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 8, 1945 at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 25 1945 to Nov. 8 1945 and that I last saw him alive on Nov. 8 1945

Immediate cause of death: Cachexia — Duration: 2 mos.
Due to: Lymphosarcoma — Duration: 1 mos.
Due to — Duration:
Other Conditions — Duration:
(Include pregnancy within 3 months of death)
Date of operation 10/IX/45
Major findings of operation: Biopsy; Lymphosarcoma
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Stafford C. Warren
Address Johns Hopkins Hosp. Date signed 11/9/45

Huntington Williams, Md

G34023

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

G34023 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1136 W Lombard St.
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18-3
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1136 W. Lombard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles B. Whiteford

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: Widower
6 (b) Name of husband or wife: late Margaret A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 19th 1874

8. AGE: Years 71 Months 7 Days 2 If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Charles Whiteford
13. Birthplace Md

MOTHER
14. Maiden Name Unknown
15. Birthplace Md

16 (a) Informant Miss Margaret Healey.
(b) Address 1941 W Lexington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 12 45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location 3801 Frederick Ave

18 (a) Funeral director John J Cowan & Son
(b) Address 901-03 Fulton St

19 (a) Received NOV 10 1945 (b) Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 9th 1945, at 4:47 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/7/45 19 , to 11/9/45 19 , and that I last saw h[e] alive on 11/8/45 19

Immediate cause of death	Duration
Acute Myocarditis	2 days
Due to Cancer of Liver	6 months
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm F Bowen M.D.
Address 1211 Edmondson Ave Date signed 11/9/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34024

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 B

G34024 Registered No. 44

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 1 HR.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Essex
(If outside city or town limits, write RURAL and give town)
(d) Street No. Mace Ave. Bet 10
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Rudolph Fehlauer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M.

5. Color or race W.

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Carnatine ne Hane

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10 - 1876

8. AGE: Years 69 Months 4 Days 29 If less than one day hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Balto. Co.

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Leonard Fehlauer
(b) Address 5313 Plymouth Rd. Balto 14

17 (a) Burial (b) Date thereof Nov. 10-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Baltimore Co.

18 (a) Funeral director John S. Connolly
(b) Address Essex, Md.

19 (a) NOV 9 45 (b) John S. Connolly
(Date rec'd by registrar) Registrar

Burlington Hotel Balto. Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-8 1945, at 1.05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-8 1945, to 11-8 1945 and that I last saw him alive on 11-8 - 1945

Immediate cause of death Gastric Hemorrhage

Due to ca (probably)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A H Frye Jr M. D.

Address Maryland Gen Hosp Date signed 11-8-45

X

G34025

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G34025

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address GREENE & REDWOOD STS.
(c) Hospital or institution:
UNIVERSITY HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County BALTIMORE
(c) City or town LOCH RAVEN
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME FRANK G. PIERCY

3 (b) If veteran, name war: World War 1

3 (c) Social Security Account No. none

4. Sex: MALE

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of ~~husband~~ or wife MABEL PIERCY

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 12, 1893

8. AGE: Years 52 | Months 0 | Days 26 | If less than one day: hr. min.

9. Birthplace ILLINOIS
(Town, county, and state)

10. Usual Occupation ASST SUPT MD TRANS SER.

11. Industry or business

FATHER
12. Name WILLIAM PIERCY
13. Birthplace KENTUCKY

MOTHER
14. Maiden Name MARGARET Harman
15. Birthplace Ky.

16 (a) Informant Mrs. Mabel Piercy
(b) Address Loch Raven, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/12/45 (month) (day) (year)
(c) Cemetery or crematory Moreland Memorial
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by reg.) NOV 10 1945 (b) Huntington Williams, M.D.

VS 100

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/8 19 45, at 6.20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/5 19 45 to 11/8 19 45 and that I last saw him alive on 11/8 19 45.

Immediate cause of death CARDIAC FAILURE — Duration

Due to CORONARY OCCLUSION
CARDIAC INFARCTION

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: MURAL THROMBUS

of autopsy CORONARY OCCLUSION

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John M. Dennis M.D.
Address Maryland Hospital Date signed 11/8/45

G34026 BALTIMORE CITY HEALTH DEPARTMENT G34026

CERTIFICATE OF DEATH

Registered No. 124 B

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
Baltimore City, Maryland
(b) Street address 32nd. & Calvert St.
(c) Hospital or institution:
Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Harford
(c) City or town Havre de Grace
(If outside city or town limits, write RURAL and give town)
(d) Street No. 407 S. Union Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Augustus Freeborn Brown

3 (b) If veteran, name war No

3 (c) Social Security Account No. No

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married.

6 (b) Name of husband or wife ~~Harriet Mary~~

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Oct 22 - 1873

8. AGE: Years 72 Months 0 Days 17 If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Attorney

11. Industry or business

FATHER
12. Name Augustus L. Brown
13. Birthplace Maryland

MOTHER
14. Maiden Name Hartzell Wheeler
15. Birthplace England

16 (a) Informant Mary J. Brown
(b) Address 407 S. Union Ave. Havre de

17 (a) Burial (b) Date thereof Nov. 12 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Grove.
Location Aberdeen Md.

18 (a) Funeral director Pennington & Son
(b) Address Havre de Grace Md

19 (a) (Date received) NOV 10 1945 Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 8 1945 at 3 22 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 2 1945, to Nov. 8 1945, and that I last saw h[illegible] alive on Nov 8 1945.

	Duration
Immediate cause of death Cardiac failure	
Due to Cardio-renal disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Cirrhosis of liver

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Crawford M. Kirkpatrick, Jr. M. D.
Address Union Memorial Hospital Date signed 11-8-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34027

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Reg. No. G34027

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3608 Esther Place
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26-4
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3608 Esther Place (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick S. Fearson

3 (b) If veteran, name war --

3 (c) Social Security Account No. 217-20-2883

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Florence Fearson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 15, 1868

8. AGE: Years 77 | Months 9 | Days 23 24 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Watchman

11. Industry or business -

FATHER
12. Name John L. Fearson
13. Birthplace Md.

MOTHER
14. Maiden Name Martha Cartwright
15. Birthplace Md.

16 (a) Informant Mr. Wm. S. Fearson
(b) Address 3608 Esther Place

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Nov. 11/45 (month) (day) (year)
(c) Cemetery or crematory Centerville Cem.
Location Centerville Md.

18 (a) Funeral director Philip Stewart Sons
(b) Address 2024 Orleans St.

19 (a) NOV 10 1945 (Date received by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 8th. 1945 19 , at 2-30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-14-44 19 , to 11-8-45 19 , and that I last saw h alive on 11-8-45 19 .

Immediate cause of death: Arteriosclerotic Heart Disease — Duration 2½ yrs.
Due to: Arteriosclerosis
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature John Costantine M.D.
Address 234 E. Conkling Date signed 11-9-45

VS 150

X

G34028

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

G34028 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1811 N. Port St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1811 N. Port St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert B. Hoffman Hofmann

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 17th 1867

8. AGE: Years	Months	Days	If less than one day
77	10	23	hr. min.

9. Birthplace Germany
(Town, County, and state)

10. Usual Occupation Baker

11. Industry or business

FATHER
12. Name Christian Hofmann
13. Birthplace Germany

MOTHER
14. Maiden Name —
15. Birthplace Germany

16 (a) Informant Christian Hofmann
(b) Address 1811 N Port St

17 (a) Burial (b) Date thereof Nov 12th 1945
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory St Matthews
Location O'Donnell St Ext

18 (a) Funeral director Leo J. Cook
(b) Address 1701-03 N Patterson Park Ave

19 (a) (b) Huntington Wilkinson, M.D.
(Date received by registrar) NOV 10 1945 (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 9th 1945, at 8:45 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy on Nov 9th thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Nov 9th death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Fratcher M.D.
Medical Examiner.
Date signed 11-9-45

G34029

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1579

Registered No. G34029

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Mukeland & Ragnor
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Except (If outside city or town limits, write RURAL and give town)
(d) Street No. #10 Bank Court Ct #13 (If rural give location)
(e) Citizen of foreign country? yes 21 (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Stuff

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife none

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/13/45

8. AGE: Years | Months | Days 21/24 | If less than one day hr. min.

9. Birthplace 364 B. Ct #13 Zone 2 (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Carter Stuff
13. Birthplace ?

MOTHER
14. Maiden Name Guarantee ?
15. Birthplace ?

16 (a) Informant Hospital
(b) Address —

17 (a) ..... (b) Date thereof ..... (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School NOV 8 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 NOV 10 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/6/1945, at 2 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/13 1945, to 11/6 1945, and that I last saw h alive on 11/6 1945.

Immediate cause of death	Duration
Aspiration Pneumonia	
Due to Pyloric Stenosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 10-28-45
Major findings of operation: Pyloric Stenosis
of autopsy: Aspiration Pneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Emil W. Bardenheuer
Address West Baltimore General Hosp Date signed 11/7/45

VS 150

F 3074

634030

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. 634030

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2028 E. Lafayette Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2028 E. Lafayette Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Harry N. Selvage

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife Emma I. Huhn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 7, 1881

8. AGE: Years	Months	Days	If less than one day
64	0	0	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Charles
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary Schissler
15. Birthplace Baltimore

16 (a) Informant Mrs. Ida W. Meil
(b) Address 2028 E Lafayette Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/10/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North Ave & Rose St.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 N. Broadway

19 (a) 11-9-1945 (Date received by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 7- 1945, at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 2- 1945, to Nov 7- 1945 and that I last saw h~~im~~ alive on Nov 2- 1945

Immediate cause of death	Duration
Eczema Lungs	4 days
Due to Cerebral Hemorrhage	14 days
Due to Arterio Sclerosis	5 yrs
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. Gill Hall M. D.
Address 1631 E. North Ave Date signed Nov 7 45

G34031 — BALTIMORE CITY HEALTH DEPARTMENT — G34031

CERTIFICATE OF DEATH

Registered No. 170 C

Every item of information should be carefully answered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2258 Marion St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Virgie Johnson

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: W

6 (b) Name of husband or wife: Sarah
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/5/1904

8. AGE: Years 41 | Months - | Days 3 | If less than one day hr. min.

9. Birthplace Chas. Co. Md (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER — 12. Name Lloyd Chase
13. Birthplace Prince Geo. Co. Md

MOTHER — 14. Maiden Name Mary E. Thomas
15. Birthplace Chas. Co. Md.

16 (a) Informant Eleanor Royster
(b) Address Edmondston Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 | 12 | 45 (month) (day) (year)
(c) Cemetery or crematory Lay Plots
Location Md. Ft. Lafayette

18 (a) Funeral director Geo. E. Pelham
(b) Address 1303 Presstman St.

19 NOV 10 1945 Interring for Williams & P

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 8th 1945, at 3:20 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Contusion of brain
Ruptured liver
Fracture of right tibia and fibula.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11/4/45 at 9:35 P.M. 12/3
(b) Where did injury occur? Eutaw Place & Whitelock St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no
(d) Means of injury Struck by auto

23. Signature Benedict Shuterbrie M.D. (Medical Examiner)
Date signed 11-8-45

VS 151

G34032

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1927

G34032

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BORDER RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1818 Lorman St.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-2

(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1818 Lorman St. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Ethel McCoy

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F

5. Color or race Col

6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife Willie McCoy

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-10-02

8. AGE: Years 43 | Months - | Days 27 | If less than one day ... hr. ... min.

9. Birthplace Virginia (Town, county and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER

12. Name Unknown

13. Birthplace Unknown

MOTHER

14. Maiden Name Mollie Asburn

15. Birthplace Virginia

16 (a) Informant Eva Stewart

(b) Address 1818 Larman St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/11/45 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location Md.

18 (a) Funeral director Geo. H. Kelson

(b) Address 1303 Pennsylvania Ave.

19 (a) NOV 10 1945 (Date received by registrar) Thurlington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-7- 1945, at 7:00 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-28- 1945 to 11-7- 1945 and that I last saw h. alive on 11-7- 1945

Immediate cause of death: Chronic Valvular Heart Disease — Duration: 1 yr.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN, Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence ... at ... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature George [illegible]

Address 1516 N. Monument St. Date signed 11-10-45 M. D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34033

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G34033

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2237 Brunt St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 3
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2237 Brunt St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George W. Brown.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M

5. Color or race Col.

6 (a) Single, married, widowed, or divorced. M.

6 (b) Name of husband or wife Sula Brown

6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) 12-22-79

8. AGE: Years 65 | Months 10 | Days 16 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation none.

11. Industry or business

MOTHER / FATHER

12. Name George Brown

13. Birthplace Md.

14. Maiden Name Sarah Wheelan

15. Birthplace Md.

16 (a) Informant Sula Brown

(b) Address 2237 Brunt St.

17 (a) Burial (b) Date thereof 11/12/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Olivet
Location Md

18 (a) Funeral director Geo. B. Kelton

(b) Address 1303 Pennsylvania Ave

19 NOV 10 1945 (b) Huntington Williams, M.D.
(Date rec'd by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-8- 1945; at 10:25 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-25 1945 to 11-8- 1945 and that I last saw h[illegible] alive on 11-8- 1945

Immediate cause of death Cerebral Hemorrhage — Duration 14 days

Due to Hypertension — 3 yrs

Due to

Other Conditions Hemiplegia — 8 yrs.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature George C. Page M. D.

Address 1516 N. Mount St Date signed 11-10-45

G34034

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1938

Registered No. G34034

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 1120 Gilmore
(b) Street address Balto Md
(c) Hospital or institution: 16

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 20

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto Md 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1120 Gilmore
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Ward

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Col	Widow

6 (b) Name of husband or wife Andrew Ward
6 (c) If alive, give age ——— years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years	Months	Days	If less than one day
61	—	—	hr. ——— min.

9. Birthplace Chesterfield Va
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name David White
13. Birthplace unknown

MOTHER
14. Maiden Name Young
15. Birthplace unknown

16 (a) Informant Ethel Turner
(b) Address 2201 Penn Ave

17 (a) Burial (b) Date thereof 11/12/45
(Burial, cremation, or removal) (Day) (Month) (Year)
(c) Cemetery or crematory Arlington Park Cem
Location A. G. Co. Md.

18 (a) Funeral director Graff Alexander
(b) Address 929 N. Mount St.

19 NOV 10 1945 (b) Huntington Williams M.D.
(Date received by local registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 9 — 1945, at 10:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-6 1945, to 11-9- 1945, and that I last saw h[illegible] alive on 11-8- 1945.

Immediate cause of death Cerebral Hemorrhage, Myocarditis
Coabuth — Duration

Due to Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thos R. Boykin M. D.
Address 1135 Gilmor Date signed 11/10/45

VS 3

G34035

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G34035

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or Institution: South Baltimore General 22
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dont
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 420 S. Charles Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Burley

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: William Garrison Burley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 1886

8. AGE: Years 59 | Months | Days | If less than one day hr. min.

9. Birthplace: A. A. County, Maryland
(Town, county, and state)

10. Usual Occupation: Housework

11. Industry or business

FATHER
12. Name: Diggs Clark
13. Birthplace: A. A. County

MOTHER
14. Maiden Name: Jannie Clark
15. Birthplace: A. A. County

16 (a) Informant: Mary Harris
(b) Address: 420 S. Charles St.

17 (a) (Burial, cremation, or removal) (b) Date thereof: 11 1 46 (month) (day) (year)

(c) Cemetery or crematory: St. Marks A. A. Co
Location: Balto. A. A. Co. Md.

18 (a) Funeral director: Walter B. Spriggs
(b) Address: 729 W. Hamby St.

19 NOV 10 1945 (Date rec'd by registrar) Huntington Williamsburg

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/7/45 19..., at 6:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio Vascular Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Watts M.D.
Medical Examiner
Date signed 11/8/45

G34036

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1107

G34036 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1107 Somerset St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1107 Somerset St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Percy L. Allen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/21/45

8. AGE: Years | Months | Days 16 | If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name George Allen
13. Birthplace Va

MOTHER
14. Maiden Name Otis Curtis
15. Birthplace Va

16 (a) Informant Otis Allen
(b) Address 1107 Somerset St

17 (a) Burial (b) Date thereof 10 10 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location B. C. & Co.

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St

19 (a) NOV 10 1945 (b) Registered by (signature) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 2 45, 19, at 7:30 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bronchopneumonia.

Due to

Other Conditions Rickets.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Shatarulee M.D.
Medical Examiner.
Date signed November 7, 1945.

VS 151

Dr. Le Vin
211 W. Monument St.

G34037

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131 B

Registered No. G34037

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2703 List Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2703 List Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles J. Valenza

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-12-7810

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Helen May
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 23, 1921

8. AGE: Years	Months	Days	If less than one day
24	4	17 16	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business Bendix Radio

FATHER
12. Name James Valenza
13. Birthplace Italy

MOTHER
14. Maiden Name Sarah Rodey
15. Birthplace Italy

16 (a) Informant Mrs. Helen M. Valenza
(b) Address 2703 List Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/12/45 (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) NOV 10 1945 (Date received by city registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 9th, 1945 at 8 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/27/1945 to 11/9/1945 and that I last saw him alive on 11/8/1945.

Immediate cause of death Chronic Carditis (mitral, aortic and tri-cuspid). Cardiac Hypertrophy and Dilitation. — Duration 7 yrs.

Due to

Due to

Other Conditions Chronic Tonsillitis (remanental). Nasal Septal Perforation. Chronic Nephritis. — Duration 7 yrs

(Include pregnancy within 3 months of death)

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M B Levin M.D.

Address 211 W. Monument St. Date signed 11/9/45

X

Dr. Sawyer
4808 Harford Rd.
634038

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

107

Registered No. 634038

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3110 Hamilton Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3110 Hamilton Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Philomena Dunn

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	widowed

6 (b) Name of husband or wife Joseph C. Dunn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4, 1868

8. AGE: Years	Months	Days	If less than one day
77	4	5	hr. min.

9. Birthplace Long Green, Maryland
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Maximillian Herzog
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret ?
15. Birthplace ?

16 (a) Informant Mrs. Margaret Sydnor
(b) Address 3110 Hamilton Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/12/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) NOV 11 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 9th, 1945 at 2 37 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 27 1945 to Nov 9 1945 and that I last saw HER alive on Nov. 8 1945.

Immediate cause of death Bronchio-pneumonia — Duration 2 days
Due to Generalized arteriosclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature George Sawyer, M.D.
M. D.
Address 4808 Harford Rd. Date signed 11/9/45

X

G34039

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G34039 Registered No.

PRESERVED FOR BINDING MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: St. Agnes Hospital
(a) Baltimore City, Maryland
(b) Street address Eastern & Wilkens Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 wks.
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County KENT
(c) City or town ROCK HALL
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Daisy Beck

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Fe.

5. Color or race W.

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife WM. BECK

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) SEPT. 2, 1879

8. AGE: Years 66 | Months 2 | Days 8 | If less than one day hr. min.

9. Birthplace MARYLAND. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name THOMAS CROUCH
13. Birthplace MARYLAND.

MOTHER
14. Maiden Name JANE
15. Birthplace MARYLAND

16 (a) Informant Hospital Record.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof NOV. 13, 1945 (month) (day) (year)
(c) Cemetery or crematory Wesley Chapel.
Location Rock Hall Md.

18 (a) Funeral director J. Willis Wells
(b) Address CHESTERTOWN, Md.

19 (a) NOV 1 1945 (Date received by registrar) (b) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/10/45 19 , at 8 10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/28 1945 to 11/10 19 45 and that I last saw h[illegible] alive on 11/10 19 45

Immediate cause of death Cardiac failure — Duration

Due to Arterio Sclerosis — Duration

Due to Cerebral Embolism giving a left hemiplegia — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Clifford Calvert M.D.
Address St. Agnes Hosp Date signed 11/12/45 M.D.

Huntington Williamsville, Md

G34040 BALTIMORE CITY HEALTH DEPARTMENT G34040
CERTIFICATE OF DEATH 937
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution:
Maryland General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: Cecil Co.
(a) State Md (b) County Harford
(c) City or town Port Deposit
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dr. William Griffith Jack

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Margaret Jack
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1862

8. AGE: Years 62 | Months | Days | If less than one day hr. min.

9. Birthplace Port Deposit Md.
(town, county, and state)

10. Usual Occupation Dr.

11. Industry or business

FATHER
12. Name William Jack
13. Birthplace Port Deposit Md

MOTHER
14. Maiden Name Sarah J. Griffith
15. Birthplace Port Deposit Md

16 (a) Informant Mrs. Wm. Jack
(b) Address Howard Alley Md.

17 (a) Buried (b) Date thereof Nov 14, 1945
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or ~~crematory~~ Fairview
Location Port Deposit Md.

18 (a) Funeral director J. C. Tyson
(b) Address Rising Sun Md.

19 (a) NOV 11 1945 Huntington Williams M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/10 1945 at 11:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/3 1945 to 11/10 1945 and that I last saw h. alive on 11/10 1945

Immediate cause of death: Respiratory Failure — Duration:

Due to: Multiple Neuritis, Chronic Myocarditis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Morton E. Strobel M. D.
Address Md. Gen'l Hospital Date signed 11/10/45

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34041

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G34041

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2510 Greenmount Ave.
(c) Hospital or institution: Southern Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 mos
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 237 No. Gilmor St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna M. Schuster

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Fe

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Henry Schuster
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 10, 1865

8. AGE: Years 80 | Months 6 | Days 30 | If less than one day ... hr. ... min. 29

9. Birthplace Balto
(Town, county, and state)

10. Usual Occupation Nurse

11. Industry or business

FATHER
12. Name Joseph Moelter
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Knauss
15. Birthplace Germany

16 (a) Informant Mrs Mary Munro
(b) Address 3100 Louise Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 12, 45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4430 Belair Rd.

18 (a) Funeral dir. John O. Mitchell & Sons Inc
(b) Address 1900 Eutaw Place,

19 (a) Date received by local registrar NOV 14 1945 (b) Washington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 9, 1945 19 ... at 1 30P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 27 1945 to Nov 9 1945 and that I last saw h[illegible] alive on Nov 5 1945

Immediate cause of death	Duration
Cardiac Decompensation	Oct 28 1945
Due to	
Due to	
Other Conditions Chronic Myocarditis Arteriosclerosis (Include pregnancy within 3 months of death)	A Number of Years.

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury —

23. Signature Morris B. Green M. D.
Address 3009 Evergreen Ave Date signed 11/11/45
Baltimore 14 Maryland.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RETAIN RESERVED FOR BINDING

G34042

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13a

Registered No. G34042

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3504 E Lombard St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No 3504 E Lombard (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Fornoff

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Elizabeth Fornoff
6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) July 4-1879

8. AGE: Years	Months	Days	If less than one day
66	4	5	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation
11. Industry or business Grocer

FATHER
12. Name Peter Fornoff
13. Birthplace Bermuda

MOTHER
14. Maiden Name Elizabeth Vogle
15. Birthplace Germany

16 (a) Informant Peter Fornoff
(b) Address 3504 E Lombard

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 10th (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans St

19 (a) (Date rec'd by registrar) (b) Registrar

NOV 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 9 1945, at 11:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1945 to Nov 9 1945. and that I last saw him alive on Nov 19

Immediate cause of death Uremia — Duration 2 days

Due to Chronic Nephritis

Due to Arterio-Sclerotic Cardio-Vascular disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Balto Date signed 11/9/45

G34043

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G34043

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1322 Edison Highway.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1322 Edison Hyway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Josephine M Koehler
If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Chas. J. Koehler
6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) Mar 23 1890

8. AGE: Years	Months	Days	If less than one day
55	7	16	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation At Home
11. Industry or business

FATHER 12. Name James A Sullens
13. Birthplace Balto

MOTHER 14. Maiden Name Margaret Lee
15. Birthplace Balto

16 (a) Informant Chas J Koehler
(b) Address 1322 Edison Highway

17 (a) Burial (b) Date thereof Nov 12
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location City

18 (a) Funeral director Leo Reitz Funeral Home
(b) Address 2008 Orleans St

19 (a) (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 8, 1945, at 10:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 3, 1945 to Nov. 8 1945, and that I last saw her alive on Nov. 8, 1945.

Immediate cause of death Cerebral Hemorrhage — Duration 2 hours
Due to Hypertensive Cardio-Vascular Renal Disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Edward L Wolfe M. D.
Address 1331 Eastern Ave Date signed 11-9-45

NOV 11 1945

VS 150

G34014

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

51B

G34014
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The street age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) About 41 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 710 Harvey St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert Frank

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Minnie Frank (Lee Kuhn) 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 2, 1864

8. AGE: Years	Months	Days	If less than one day
81	0	6	hr. min.

9. Birthplace England (Town, county, and state)
10. Usual Occupation Retired At Home
11. Industry or business

FATHER
12. Name ? Don't Know
13. Birthplace England

MOTHER
14. Maiden Name ? Don't Know
15. Birthplace England

16 (a) Informant B. C. H. Records & Mrs. Eliz. M.
(b) Address 4940 Eastern Ave. Home.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 12, 1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto., Md.

18 (a) Funeral director J. Howard Eversmeyer
(b) Address 1400 St. Paul St. Balto. 39 Md.

19 (a) NOV 14 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 8, 1945 19 at 4.15P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 6 1945, to Nov. 8 1945, and that I last saw h im alive on Nov. 8 1945.

Immediate cause of death Hemorrhage — Duration 3 days
Due to peptic ulcer
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
Findings of autopsy C.A. prostate, peptic ulcer

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Margaret Davis
Address 4940 Eastern ave Date signed 11/9/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34045

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93D

✓ G34045 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai Hospt.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED: W. 0864
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1401 E. Belvedere (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Weinstein

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Dead
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1864

8. AGE: Years 81 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Hospt Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-11-45 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Pratt Rd Hamilton Ave

18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E. Fulton St

19 (a) NOV 11 1945 (Date rec'd by registrar) (b) Registrar Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-9-45 19 , at 5.40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-8-1945 to 11-9-1945 and that I last saw her alive on 11-9-1945

Immediate cause of death	Duration
Arteriosclerotic Heart Disease	
Due to Coronary Sclerosis Myocardial fibrosis	
Due to	
Other Conditions Pulmonary Edema	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Bertha Rader M. D.
Address Sinai Hosp. Date signed 11-9-45

VS 150

X

G34046

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G34046 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai Hospt 6 S
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 136 Jackson Pl (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Liebstein, Simon

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 1862

8. AGE: Years 83 | Months | Days | If less than one day hr. min.

9. Birthplace: Russia (Town, county, and state)

10. Usual Occupation: None

11. Industry or business

FATHER
12. Name: Eliezar
13. Birthplace: Russia

MOTHER
14. Maiden Name: Lolg
15. Birthplace: Russia

16 (a) Informant: Hospt Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-11-45 (month) (day) (year)
(c) Cemetery or crematory: Adas Israel
Location: North Point Rd.

18 (a) Funeral director: Jack Levin Inc
(b) Address: 1439 E Balto St

19 (a) 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 10 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 26 1945 to Nov 10 1945, and that I last saw him alive on Nov 10 1945.

Immediate cause of death	Duration
cerebral hemorrhage	
Due to hypertension and arteriosclerosis	
Due to uremia	
Other Conditions pneumonia	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leonard Schultz

Address Sinai Hospital Date signed M. 11 D. 10 '45

X

G34047 BALTIMORE CITY HEALTH DEPARTMENT G34047
CERTIFICATE OF DEATH 92 B Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3444 Auchentoroly Ter
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3444 Auchentoroly Ter
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rev Abraham Selsky
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced married
6 (b) Name of husband or wife Sonya
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1868
8. AGE: Years 77 | Months | Days | If less than one day hr. min.
9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Reverend
11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Wife
(b) Address
17 (a) Burial (b) Date thereof (month) June (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory Chapel Hill
Location Woodlawn
18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Pratt St.
19 (a) 11 1945 (b) [illegible] Md
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 14-10-1945, at 12:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1933 19 to 10/10 1945.
and that I last saw him alive on 10/9 1945

Immediate cause of death Acute cerebral hemorrhage — Duration 30 days
Due to arteriosclerosis — 5 yrs
Aortic stenosis & insufficiency
Due to rheumatic fever
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature Meeta Blum
Address 2904 Rustic Ridge Rd Date signed 11/10/45

VS 150

G34048

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G34018

B54a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 da.
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Dunmanskin Garrison
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Jean Rosenstein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mrs E. S. Rosenstein
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 9, 1889

8. AGE: Years	Months	Days	If less than one day
56	0	1	hr. min.

9. Birthplace Baltimore, Md -
(Town, county, and state)
10. Usual Occupation Financial business
11. Industry or business

FATHER
12. Name Louis Rosenstein
13. Birthplace Germany

MOTHER
14. Maiden Name Rothschild Rosalie Blum
15. Birthplace Germany

16 (a) Informant Mrs. Nanette M. Rosenstein
(b) Address Emerson Apts.

17 (a) Burial (b) Date thereof 11/12/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Baltimore Hebrew
Location Baltimore, Md.

18 (a) Funeral director Harris Levinthal & Son
(b) Address 1902 Eutaw Place

19 (a) Date rec'd by registrar NOV 14 1945 (b) Huntington Williams, M.D. Registrar

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH November 10 1945, at 12 o'clock noon M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 5 1945, to Nov 10 1945, and that I last saw him alive on Nov. 10 1945.

Immediate cause of death Brain Tumor (Probable glioma of left frontal lobe)

Duration: Symptoms of 2 weeks

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Nov. 10, 1945

Major findings of operation: Brain tumor

of autopsy:

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. L. Sweet III M. D.
Address Union Memorial Hospital Date signed 11-10-45

PHYSICIAN
Underline the cause to which death should be charged statistically.

G34049

BALTIMORE CITY HEALTH DEPARTMENT ✓ G34019
Registered No.

CERTIFICATE OF DEATH 130

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1134 East North Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State ~~Md~~ West Virginia (b) County
(c) City or town Clarksburg
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Darice Sargent

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	White	Married

6 (b) Name of husband or wife Harriet Sargent
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 20 1897

8. AGE: Years	Months	Days	If less than one day
47	10	19	hr. min.

9. Birthplace W Va (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Okey O Queen
13. Birthplace W Va

MOTHER
14. Maiden Name Matilda Marple
15. Birthplace W Va

16 (a) Informant Harriet Sargent
(b) Address 1134 East North Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/10/45 (month) (day) (year)
(c) Cemetery or crematory Monumental
Location Clarksburg W Va

18 (a) Funeral director Wilson Lee Fry
(b) Address 1217 E Fort St

19 NOV 14 1945 (Date rec'd by registrar) Registrar

(Huntington Publishing Co)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 10 1945, at 12 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-2-1945 to 11-9 1945, and that I last saw her alive on 11-9-1945

Immediate cause of death	Duration
Uremic Poisoning	
Due to Acute nephritis	3 months
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Bowman C. Hood M. D.
Address 220 Garrison Blvd. Date signed 11-11-45

X

G34050
365-812

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

526

G34050
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va. (b) County
(c) City or town Baxter
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel J. Barr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	Sep.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-3-80

8. AGE: Years	Months	Days	If less than one day
65	1	8	hr. min.

9. Birthplace W. Va. (Town, county, and state)
10. Usual Occupation coal miner
11. Industry or business

FATHER
12. Name Isaac Barr
13. Birthplace W. Va.

MOTHER
14. Maiden Name Mary Wise
15. Birthplace W. Va.

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Nov 11/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Fairmont W. Va

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 1900 Eutaw St

NOV 12 1945
(Date received by Registrar)
(b) Huntington Williams M.D.
(Signature of Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov- 11 1945 at 12 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-16- 1945 to 11-11- 1945 and that I last saw h[illegible] alive on 11-10- 1945

Immediate cause of death Pulmonary embolism of Coronary Occlusion

Due to Phlebo-thrombosis

Due to Metastatic intestinal transplantation bilateral

Other Conditions Carcinoma ? bladder
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert S. Mayer M. D.
Address Johns Hopkins Hosp Date signed 11-11-45

G34051

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93

G34051

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution: Monument & Rutland Ave
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15+
(e) Length of stay in Baltimore (yrs., mos., or days) 34 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1712 N. Appleton St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Sonia Talesnick

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Samuel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1895

8. AGE: Years	Months	Days	If less than one day
50			hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business House Wife

FATHER
12. Name Morris Findur
13. Birthplace Russia

MOTHER
14. Maiden Name Florence Levin
15. Birthplace Russia

16 (a) Informant Samuel Talesnick
(b) Address 1712 N Appleton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 12, 1945 (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cem
Location Hamilton Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

NOV 12 1945 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 11 1945 at 3:05 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 10 1945, to Nov 11 1945, and that I last saw her alive on Nov 11 1945.

Immediate cause of death	Duration
pulmonary edema	
Due to hypertension arteriosclerosis cardiac - coronary disease	
Due to	
Other Conditions cerebral hemorrhage	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leonard Schulz M. D.
Address 1500 Eutaw Pl Date signed 11/11

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34052

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

164c

Registered No. G34052

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: University Hosp 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 410 W. Mulberry St
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Jean W. Bowen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or~~ divorced.
M	W	Married

6 (b) Name of ~~husband or~~ wife Jeanette Bowen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 22nd 1878

8. AGE:	Years	Months	Days	If less than one day
	70	3	18	.....hr. .....min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation Night Watchman

11. Industry or business Roberts (Jeweler)

FATHER
12. Name Thomas Bowen
13. Birthplace Balto. Co. Md.

MOTHER
14. Maiden Name Mary R. Digney
15. Birthplace Balto. Md.

16 (a) Informant Jeanette Bowen
(b) Address 410 W. Mulberry St.

17 (a) Burial (b) Date thereof 11/13/45
(Burial, ~~cremation, or removal~~) (month) (day) (year)

(c) Cemetery ~~or crematory~~ Pleasant Hill
Location Balto. Co. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

NOV 12 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 11 1945, at 1 05 A.M.

21. I certify that I took charge of the remains described above, held an Inquest & Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet Wound of Head

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Nov 11, 1945 12 10 A.M.
(b) Where did injury occur? 410 W. Mulberry St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Shot self

23. Signature Robert L. Graham M.D.
Medical Examiner.
Date signed Nov 11 1945

G34053

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157c

Registered No. G34053

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline + Hoffman Sts.
(c) Hospital or institution:
St. Joseph's Hosp. 8-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2218 E. Chase St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Herfurth

3 (b) If veteran, name war: N
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov. 10, 1945

8. AGE: Years	Months	Days	If less than one day
			hr. 10 min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Newborn Baby
11. Industry or business

FATHER
12. Name Charles William Herfurth
13. Birthplace Pittsburgh, Pa.

MOTHER
14. Maiden Name Marguerite A Stuber
15. Birthplace Trappe, Md.

16 (a) Informant Mrs. C. W. Herfurth
(b) Address 2218 E. Chase St.

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 11/12/45 (month) (day) (year)
(c) Cemetery Balto.
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 E. Paul St.

NOV 12 1945 Washington Williams M.D. Registrar
(Date rec'd by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 10 1945, at 7:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/10 1945 to 11/10 1945 and that I last saw h[illegible] alive on 11/10 1945.

Immediate cause of death	Duration
Anencephalic monster	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. H. Frank M. D.
Address Caroline & Hoffman Sts Date signed 11/10/45

X

G34054

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93E

G34054 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Give the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1709 N Bond St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 mo
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1709 N Bond St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William E Heck

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Elizabeth
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1883

8. AGE: Years	Months	Days	If less than one day
62	8		hr. min.

9. Birthplace Contractor
(Town, county, and state)
10. Usual Occupation Silk
11. Industry or business

FATHER
12. Name John C Heck
13. Birthplace Germany

MOTHER
14. Maiden Name Katherine Von Boner
15. Birthplace Germany

16 (a) Informant Albert Heck
(b) Address 2606 Clifton Park Terrace

17 (a) Funeral (b) Date thereof 11/13/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Montclair Cem
Location Baltimore Co Md

18 (a) Funeral director Welhorn Eck Inc
(b) Address 1217 E Lexington St

19 (a) Date received by registrar (Signature) for Williams, M.D. Registrar

NOV 12 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 10 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1 1945 to Nov. 10 1945, and that I last saw him alive on Nov. 10 1945.

Immediate cause of death	Duration
Myocarditis	
Due to	
Due to	
Other Conditions Edema Lungs	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert Heck

Address 1823 N. Broadway St. Date signed 11/10/45 M. D.

X

G34055

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46F

Registered No. G34055

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greene & Lombard
(c) Hospital or institution: University Hospital 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6302 Everall Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eaton Sharples

3 (b) If veteran, name war: W
3 (c) Social Security Account No. 218-09-1055

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Edith Sharples
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 12-1878

8. AGE: Years 67 | Months 5 | Days 28 | If less than one day: hr. min.

9. Birthplace England
(Town, county, and state)

10. Usual Occupation Supt. Sport mod
11. Industry or business Bell Telephone Shop Fab

FATHER
12. Name John Sharples
13. Birthplace England

MOTHER
14. Maiden Name Anne Faulkner
15. Birthplace England

16 (a) Informant George Coles
(b) Address 6302 Everall Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/13/45 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Parkville Md

18 (a) Funeral director Tilhorn & Ockershausen
(b) Address 1214 St Paul St

NOV 12 1945 (Date rec'd by registrar) Registrar for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 10 19 45, at 1:40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 28 19 45 to Nov 10 19 45, and that I last saw h. im alive on Nov 10 19 45.

Immediate cause of death	Duration
Respiratory failure	
Due to Cerebral Metastasis	
Due to Carcinoma of Gallbladder	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William H. Robinson M.D.
Address Univ. Hosp. Date signed 11/10/45

VS 150

G34056

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G34056

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4 North Carey Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 D
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4 North Carey Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bettie Ada Dixon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife James W. Dixon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 8 1854

8. AGE: Years 91 | Months 10 | Days 2 | If less than one day ____ hr. ____ min.

9. Birthplace West Moreland County Va. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Norman A. Dixon
(b) Address 4 N. Carey St. Apt. 7

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 13, 1945 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto Md.

18 (a) Funeral director E. P. Little
(b) Address 4008 Edmondson Ave

NOV 12 1945 (Date received by local registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/10/45 19 ..., at 8:55 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis M.D. Medical Examiner.
Date signed 11/10/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634057

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. 634057

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3004 Clearspring Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3004 Clearspring Rd (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME: ROSA WEIGEL

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Charles B. Weigel
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug. 7. 1872

8. AGE: Years 73 | Months 3 | Days 5 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Peter Scheflein
13. Birthplace Germany

MOTHER
14. Maiden Name Matilda Herman
15. Birthplace Germany

16 (a) Informant Miss Irene Weigel (Daughter)
(b) Address 3004 Clearspring Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 12. 1945 (month) (day) (year)
(c) Cemetery or crematory Prospect Hill Cem.
Location Towson Md.

18 (a) Funeral director HENRY SANDER & SONS. INC.
(b) Address North Ave. & Broadway.

19 (a) NOV 12 1945 (Date received by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 9, 1945 at 11 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 11 1945 to 11 9 1945.
and that I last saw h[illegible] alive on 11 8 1945

Immediate cause of death: Ren. Failure. Uremia — Duration: 6 hrs
Due to Chronic Myocarditis
Due to
Other Conditions Diabetes
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Irving L. D. Sander
Address 3376 E. Baltimore St. Date signed 11/11/45

93D

G34058

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. G34058

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dukeland and Rayner St
(c) Hospital or institution: West Baltimore General Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 days
(e) Length of stay in Baltimore (yrs., mos., or days) 82 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County -------
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 204 E. 32nd St. (If rural give location)
(e) Citizen of foreign country? ------- (Yes or No)
If yes, name country -------

3 (a) FULL NAME Lucille E Campbell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife John A. Campbell

6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) --------

8. AGE: Years	Months	Days	If less than one day
About 79	---	---	-- hr. --- min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business -------

FATHER
12. Name George W. Wingate
13. Birthplace Maryland

MOTHER
14. Maiden Name Caroline Travers
15. Birthplace Maryland

16 (a) Informant Mrs. Fannie L. Stewart
(b) Address 204 E. 32nd Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/13/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director Henry W. Mears & Son
(b) Address 805 W. Calvert Street

19 (a) Date received by Registrar NOV 12 1945 (b) Registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-10 1945, at 3:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-11 1945 to 11-10 1945 and that I last saw her alive on 11-10 1945

Immediate cause of death	Duration
Acute Left Ventricular Dilatation	
Due to Arteriosclerosis	
Due to	
Other Conditions Fractured left femur (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence October 11, 1945 M
(c) Where did injury occur? Balto. (City or town) Md. (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? at home (Specify type of place) While at work? No
(e) Means of injury Slipped + fell to floor in home

23. Signature Benjamin Gerdelsky M. D.
Address West Balto 2-4 Day Date signed 11/12/45

VS 150

Benedict Skotarchi M.D.

G34059

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

114E

Registered No. G34059

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Herring Run & Harford Rd.
(c) Hospital or institution: Lydenham Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) <1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 9 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4141 Falls Rd
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Leroy Chilcoat

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 7, 1941

8. AGE: Years	Months	Days	If less than one day
4	0	2	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation 0

11. Industry or business

FATHER
12. Name George Chilcoat
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Bonyne Davis
15. Birthplace Baltimore, Md.

16 (a) Informant Mother
(b) Address

17 (a) Burial (b) Date thereof Nov 12/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or ~~crematory~~ Woodlawn.
Location

18 (a) Funeral director Edmondson & Donovan
(b) Address 3615-17 Chestnut Ave

19 (a) [illegible] Baltimore MD
(Signature) (Address)

NOV 12 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 9 1945, at 2 55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 8 1945 to Nov. 9 1945, and that I last saw him alive on Nov. 9 1945

Immediate cause of death	Duration
Atelectasis of rt. lung	
Due to Paralysis of rt. diaphragm	
Due to Poliomyelitis	8/23/44
Other Conditions Comma Cold.	

(Include pregnancy within 3 months of death)

Date of operation Bronchoscopy Nov. 8, 1945

Major findings of operation Trachea full of mucus

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Melchiah Spragins M.D.
Address Lydenham Hosp. Date signed 11-9-45

X

634060

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 E

Registered No. 634060

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: BON SECOURS HOSP.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town ILLCHESTER (If outside city or town limits, write RURAL and give town)
(d) Street No..... (If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME Rev. Joseph Stolz - C.S.S.R.

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NONE

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife.....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug 15 1871

8. AGE: Years 74 | Months 2 | Days 9 | If less than one day ..... hr. ..... min.

9. Birthplace NEW YORK N.Y. (Town, county, and state)
10. Usual Occupation CLERGYMAN
11. Industry or business

FATHER
12. Name UNKNOWN
13. Birthplace ?

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace ?

16 (a) Informant HOSP. RECDS.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/14/45 (month) (day) (year)
(c) Cemetery or crematory ST. MARYS COLLEGE CEM
Location ILLCHESTER MD.
18 (a) Funeral director Leslie Zeiler Inc.
(b) Address 403 E. WOLFE ST.
NOV 12 1945 (c) Huntington Williams M.D.
Registered by Registrar Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/11/1945 at 7.20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/3/1945 to 11/11/1945 and that I last saw h.. alive on 11/10/1945

Immediate cause of death: Coronary Occlusion — Duration: 24 hrs.
Due to: Arteriosclerotic C.V. Disease
Due to: Malignancy Sigmoid Colon; Resected; Colostomy
Other Conditions: 11/16/45

(Include pregnancy within 3 months of death)
Date of operation 11/16/45
Major findings of operation: Malignancy Sigmoid Colon
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....
23. Signature Chas. Norton, Jr.
Address Bon Secours Hosp. Date signed 11/14/45

The G34061

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G34061

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day.
(e) Length of stay in Baltimore (yrs., mos., or days) 2 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2008 E. Pratt St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) FULL NAME Irene Martin

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NONE
4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: GEORGE MARTIN
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): OCT. 28 1867
8. AGE: Years 78 | Months 0 | Days 12 | If less than one day: hr. min.
9. Birthplace: WEST VA. (Town, county, and state)
10. Usual Occupation: HOUSE WIFE
11. Industry or business: AT HOME

FATHER
12. Name: WILLIAM BIRD
13. Birthplace: W.VA.

MOTHER
14. Maiden Name: UNKNOWN
15. Birthplace: W.VA.

16 (a) Informant: JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof NOV. 15/45 (month) (day) (year)
(c) Cemetery or crematory BISCA CEM.
Location PRINCETON W.VA.
18 (a) Funeral director: Lilly & Zeiler Inc.
(b) Address 403 S. WOLFE ST.
NOV 19 1945 (Date rec'd by registrar) (b) Huntington for Williamson, W.Va. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 10 1945, at 5 35 M
21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 10 1945 to Nov. 10 1945, and that I last saw h.. alive on Nov. 10 1945.

	Duration
Immediate cause of death: Pulmonary Edema	
Due to: arteriosclerotic Heart disease	
Due to: Bronchial Pneumonia ? Myocardial infarct	
Other Conditions: ? Cerebral Hemorrhage	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Graham G. Vance M.D.
Address Johns Hopkins Hosp. Date signed 11/16/45

VS 150

G34052

G34052

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3501 Roland Ave
(c) Hospital or institution:

13-6

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3501 Roland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Ida B Richards

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex F/A

5. Color or race W

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife George N Richards

6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) June 18-1879

8. AGE: Years 66 | Months 4 | Days 24 | If less than one day hr. min.

9. Birthplace Balto Co. Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Tonis Meilke
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany.

16 (a) Informant Geo N Richards
(b) Address 3501 Roland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 14/45 (month) (day) (year)
(c) Cemetery or crematory Hampstead
Location Hampstead Md

18 (a) Funeral director Edw A Upton
(b) Address Hampstead Md.

(c) NOV 12 1945 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 12 1945, at 4 11 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1945, to Nov 12 1945, and that I last saw h alive on Nov. 11 1945.

Immediate cause of death Cerebral Hemorrhage — Duration 48 hrs.

Due to Hypertension — Duration years

Due to Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Helmut M. Frete
Address 282 St. Paul St Date signed Nov 12-45 M. D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

VS 3

G34063

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 128

Registered No. G34063

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 225 N. Kenwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 225 N. Kenwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Martin J. Connolly

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife Anna Mc Donough
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 2. 1866

8. AGE: Years	Months	Days	If less than one day
79			hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation Retired Carpenter
11. Industry or business

FATHER
12. Name James Connolly
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary O'Donnell
15. Birthplace Ireland

16 (a) Informant Daughter Winifred Jenkins
(b) Address 2625 Arunah Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 13-45 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director Frank V. Pistone
(b) Address 2818 E. Baltimore St

NOV 12 1945 (c) Name of [illegible] Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 10th 1945 at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 7 1945 to Nov 10 1945; and that I last saw [illegible] alive on Nov 9 1945.

Immediate cause of death	Duration
Acute Pancreatitis	1 wk
Pulmonary Edema	2 days
Decumulating Factors	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Lars Leth M. D.
Address 1132 E. Jefferson Apt 6 Date signed 11/12/45

VS 150

X

G34064

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G34064

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution: Stamford General 20 Hrs 40 Min.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1917 W. Mulberry
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Phillip Clive Emmart

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 26, 1876

8. AGE: Years	Months	Days	If less than one day
69	1	14	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Phillip T. Emmart
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Helena Winnberger
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Jos. S. Emmart
(b) Address 431 Yale Ave.

17 (a) Burial (b) Date thereof 11/13/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 NOV 12 1945 (b)
(Date received by registrar)

Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/10 1945 at 6:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/10 1945 to 11/10 1945 and that I last saw him alive on 11/10 1945

Immediate cause of death	Duration
Coronary Thrombosis	
Due to Arteriosclerotic C.V. Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Martin E. Strobel M. D.
Address Md. Gen. Hospital Date signed 11/10/45

X

G34065

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1945

Registered No. G34065

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully reported. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution: Maryland General 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2409 W. Lanvale (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hartwell M. King

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife Nellie B. King
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 2, 1880

8. AGE: Years	Months	Days	If less than one day
65	9	9	hr. min.

9. Birthplace Hanover Co., Va. (Town, county, and state)
10. Usual Occupation Lawyer
11. Industry or business

FATHER
12. Name Lucian M. King
13. Birthplace Hanover Co., Va.

MOTHER
14. Maiden Name Henrietta O. Gibson
15. Birthplace Hanover Co., Va.

16 (a) Informant Mrs. Nellie B. King
(b) Address 2409 W. Lanvale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/14/45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 12 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/11 1945 at 12:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/26 1945 to 11/11 1945
and that I last saw h[illegible] alive on 11/10 1945

Immediate cause of death	Duration
Terminal Pneumonia	
Due to Cerebral Hemorrhage	16 days
Due to Hypertension C.V. Disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Martin E. Strobl M. D.
Address Md. Gen'l Hospital Date signed 11/12/45

G34066

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1119a

Registered No. G34066

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Mercy Hosp
(c) Hospital or institution: 20-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 d.
(e) Length of stay in Baltimore (yrs., mos., or days) 16 d.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
City or town Baltimore Rural
(If outside city or town limits, write RURAL and give town)
(d) Street No. 303 Hilton Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Preston Morgan Bradley Wagner

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 26, 1945

8. AGE: Years	Months	Days	If less than one day
		16	hr. min.

9. Birthplace Mercy Hosp. Balto. (Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name Harry Wagner
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Jule Rising
15. Birthplace Massachusetts

16 (a) Informant Harry Wagner
(b) Address 303 Hilton Ave. Balto 28, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/12/45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn Md.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address North & Pa. Aves.

19 (a) (Date received by Registrar) (b) Huntington Williams M.D. (Registrar)

NOV 12 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/11 1945; at 9:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/4 1945, to 11/11 1945, and that I last saw him alive on 11/11 1945.

Immediate cause of death	Duration
a. Accidental Dehydration	
Due to Diarrhea	
Due to Prematurity	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles Statham
Address Mercy Date signed 11/11/45 (M.) (D.)

634067

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1131a

634067 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1234 Etting St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1234 Etting St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Henry B. Harmon

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-05-2502

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	Negro	Married

6 (b) Name of husband or wife Harriett Harmon
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 15, 1876

8. AGE: Years	Months	Days	If less than one day
69	2	23	hr. min.

9. Birthplace Berlin, Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Edward Harmon
13. Birthplace Maryland

MOTHER 14. Maiden Name Martha Spencer
15. Birthplace Maryland

16 (a) Informant Dr. L. E. Harmon
(b) Address 1928 Madison Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-12-45 (month) (day) (year)
(c) Cemetery or Ant. Auburn
Location Baltimore, Maryland

18 (a) Funeral director Charles E. Law
(b) Address 802 Madison Ave.

19 (a) (b) Huntington Williams, M.D.

NOV 12 1945
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 8, 1945, at 9:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1945 to Nov 8 1945 and that I last saw h[illegible] alive on Nov. 6 1945

Immediate cause of death	Duration
Bronchopneumonia	48 hrs.
Due to arteriosclerotic cardio-vascular renal disease	15 yrs.
Due to	
Other Conditions — (Include pregnancy within 3 months of death)	

Date of operation —
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature James D. Carr M. D.
Address 516 Herbert St Date signed 11.10.45

X

G34068

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. G34068

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 530 Reddnor Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 530 Reddnor Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Grace Sanner

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Harry W.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 14, 1874

8. AGE: Years	Months	Days	If less than one day
70			hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name James T. Meroaiken
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Elizabeth Lee
15. Birthplace Baltimore Md

16 (a) Informant Mrs Geo. Mullen
(b) Address 530 Radnor Ave

17 (a) Burial (b) Date thereof 11/11/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loyola Pk.
Location Frederick Ave

18 (a) Funeral director John F Henry Inc
(b) Address 415 Light St.

19 (a) NOV 12 1945 Hunting for Whitestone, Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 8th 1945, at 12:15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-12-45 to 11-8 1945 and that I last saw her alive on 11-8 1945

Immediate cause of death

	Duration
Due to Acute Dilatation of the Heart	Duration.
Due to Hypertensive Cardio Disease	Vascular ?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify home, farm or place)
(e) Means of injury

23. Signature Anthony T. Capozza M. D.
Address 527 York Rd Date signed 11-9-45

634089

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1121

Registered No. 634089

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully applied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden & Madison Ave
(c) Hospital or institution: Md. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3024 Fairmount Blvd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Buena M. Miller

3 (b) If veteran, name war —

3 (c) Social Security Account No. 263-01-1802

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband ~~or wife~~ Charles

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 9, 1916

8. AGE: Years 29 | Months | Days | If less than one day hr. min.

9. Birthplace Marsh Hill Penn
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name George Zinger ZINZER
13. Birthplace Penn

MOTHER
14. Maiden Name Verda Heylmun HEYMUN
15. Birthplace Penn

16 (a) Informant Charles Miller
(b) Address 3024 Fairmount ave

17 (a) Burial (b) Date thereof Nov 14-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Pensdale
Location Bodine - Pa.

18 (a) Funeral director E. Haworth Armacost
(b) Address 3911 Liberty Heights Ave

NOV 12 1945
(Date received by registrar)

(b) Penalty for Willfully Making False Statement

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/11 1945, at 8 20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/1 1945 to 11/11 1945 and that I last saw h~~er~~ alive on 11/11 1945.

Immediate cause of death

	Duration
Peripheral Vascular Collapse	13 da
Due to Ruptured Gang. Serous Appendix	
Due to (a)	
Other Conditions 3 mo. preg.	

(Include pregnancy within 3 months of death)

Date of operation 11/9/45

Major findings of operation: Rupture of Gangrenous app. & 3 mo. preg

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dudley Shelton M. D.

Address Date signed 11/11/45

VS 150

G34070

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G34070

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1015 Sharp St
(c) Hospital or institution: 23
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1015 Sharp St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Rev. Charles E. Braxton

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Separated

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/11/1876

8. AGE: Years	Months	Days	If less than one day
69	6	28	hr. min.

9. Birthplace Hampton Va. (Town, county, and state)
10. Usual Occupation Minister
11. Industry or business

FATHER
12. Name Nathaniel Braxton
13. Birthplace Va. Va.

MOTHER
14. Maiden Name Unknown
15. Birthplace ?

16 (a) Informant Elizabeth Braxton (Daug)
(b) Address 1015 Sharp St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/12/45 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem'l. Pk.
Location Baltimore, County, Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 512 N. Carrollton Ave. Mailing Address Millsdale, Md.

NOV 12 1945 (Date rec'd by Local Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 8th 1945 at 6P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 31 1945 to Nov. 8 1945, and that I last saw him alive on Nov. 7 1945.

Immediate cause of death	Duration
Cerebral Hemorrhage	10 hrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. D. Lacy Jr. M.D.
Address 522 Harlem Ave. Date signed 11/12/45 M. D.

VS 150

634071

HEP #97045

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 1a

Registered No. 634071

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 54 - 6 - 10

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County 5
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 35 East 21st St., Zone 18 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** William H Quinn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Divorced

6 (b) Name of husband or wife Grace Quinn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. [illegible] 1891

8. AGE: Years	Months	Days	If less than one day
54	0	0	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation unemployed
11. Industry or business

FATHER
12. Name William Quinn
13. Birthplace Ireland Md.

MOTHER
14. Maiden Name Ellen M. Murphy
15. Birthplace Maryland

16 (a) Informant Balto. City Hospitals Records
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof 11-13-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Leonard J. Lusk
(b) Address [illegible] Hartford Rd.

19 (a) 11-9-1945 (Date received by registrar) (b) Hunting for Hillcrest Md. (Location)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 9, 1945, 6:30P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1, 1945 to Nov. 9, 1945 and that I last saw him alive on Nov. 9, 1945

Immediate cause of death	Duration
Uremia	7
Due to Nephrosclerosis	7
Due to	
Other Conditions Hypertensive C-V Dis. Cardiac insufficiency	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: arteriosclerosis, contracted kidneys, Cardiac Hypertrophy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Margaret Davis

Address 4940 Eastern Ave. Date signed 11/10/45
M. D.

G340 Stevens
Harfrod & Hugo Ave.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G34072

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2826 Roselawn Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2826 Roselawn ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Eva Martin

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	married

6 (b) Name of husband or wife James T. Martin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 9, 1900

8. AGE: Years	Months	Days	If less than one day
45	1	0	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Frederick Ziegler
13. Birthplace Germany

MOTHER
14. Maiden Name Marie Bauer
15. Birthplace ?

16 (a) Informant Mr. James T. Martin
(b) Address 2826 Roselawn Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/12/45 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) NOV 12 1945 (Date rec'd by registrar) (b) Huntington Williams M. D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 9th, 1945, at 8:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1 1945 to Nov 9 1945, and that I last saw her alive on Nov 9 1945.

Immediate cause of death	Duration
Metal Regurgitation Incompetency	9 d.
Due to Chronic Nephritis	
Due to Gen. Peripheral Vascular Nephritis	9 d.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operations
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature H H a Stevens M. D.
Address 2878 Harford Rd Date signed 11-10-45

VS 150

X

G34073

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1133a

Registered No. G34073

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 300 N. CALVERT ST.
(c) Hospital or institution: MERCY HOSPITAL 24
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE. 81yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1443 Riverside Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Reiley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife DECEASED
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10 - 11 - 1864

8. AGE: Years	Months	Days	If less than one day
81	0	30	hr. min.

9. Birthplace Baltimore Md. (Town, county and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name August Fay
13. Birthplace Baltimore

MOTHER
14. Maiden Name Sophie ?
15. Birthplace Baltimore

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-13-1945 (month) (day) (year)
(c) Cemetery or crematory Holy Cross, Location A. A. Co. Md.

18 (a) Funeral director Flynn & Flannery
(b) Address 1476 Light St.

NOV 12 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-10 1945, at 11 00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-2 1945, to 11-10 1945, and that I last saw her alive on 11-10 1945.

Immediate cause of death Uremia
Kidney Failure — Duration 1 wk

Due to Arteriosclerosis and Pyelitis — Duration of Disease for 12 day

Due to

Other Conditions Congestive Heart Condn. on Admission to Hosp
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph E. Rudd M. D.
Address Mercy Hospital Date signed 11-10-45

VS 150

G34074 Lukasiewicz

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓180

G34074

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1608 Fleet ST (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Andrew Lukasiewicz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife 7

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years	Months	Days	If less than one day
62			hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name NO
15. Birthplace Poland

16 (a) Informant Joseph Lukasiewicz
(b) Address 13 S Potomac St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 13 45 (month) (day) (year)
(c) Cemetery or Crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Fred W. Ozarowski
(b) Address 1930 Eastern Ave

19 (a) NOV 12 1945 (b) Huntington Maryland

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 11 1945, at 2 A M

21. I certify that I took charge of the remains described above, held an Autopsy + Inquest thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐ suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Tetanus due to 1st, 2nd + 3rd degree burns

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury Nov 11 1945 2/3 15 1 A M.
(b) Where did injury occur? 1608 Fleet ST
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Conflagration House fire

23. Signature Robert Lee Fratcher M.D.
Medical Examiner
Date signed Nov 11 1945

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34075

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

178a

Registered No. G34075

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: University Hospital 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1.s.a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 205 N. Amity Street
(If rural give location) Apt. #2
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Burton Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Hayden

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 24 1913

8. AGE: Years 32 | Months | Days | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Frank Burton
13. Birthplace Va

MOTHER
14. Maiden Name Alice Johnson
15. Birthplace Md.

16 (a) Informant Hayden Smith
(b) Address 205 N. Amity St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 14 1945 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary Cem
Location A. A. County Md.

18 (a) Funeral director Mrs. Elbert A. Elliott
(b) Address 29 N. Carrollton St.

NOV 12 1945

(Date rec'd by registrar) Ethelrington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 9 1945, at 1:45 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carbon Monoxide poisoning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-9-45 at 12:50 P. M. 18/1
(b) Where did injury occur? 205 N. Amity St. Apt. 2
(c) Did injury occur at home, on farm, industrial place, in public place? Home. While at work?
(d) Means of injury Inhaling gas from kitchen stove on gas unlit

23. Signature Benedict Shiterek M.D.
Medical Examiner.
Date signed November 9, 1945.

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34076

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G34076 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 605 Madeira St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 605 Madeira St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Parker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Widow

6 (b) Name of husband or wife Nathaniel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 8, 1878

8. AGE: Years	Months	Days	If less than one day
67			hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name George Davis

13. Birthplace Md

MOTHER 14. Maiden Name Sarah Hall

15. Birthplace Md.

16 (a) Informant Sarah Beckham

(b) Address 605 Madeira St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/13/45 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary Cem.
Location A. A. County Md.

18 (a) Funeral director Mr. Robert A. Elliott

(b) Address 1129 N. Caroline St.

19 (a) (b)
Deputy Registrar Registrar

NOV 12 1945 Huntington Williams, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 9 1945, at 8:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 9 19 to Nov 9 1945 and that I last saw h alive on Nov 9 1945

Immediate cause of death	Duration
Cerebral Hemorrhage	2 days
Due to	
Due to	
Other Conditions Arteriosclerosis	?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. D.

Address 1427 N Carlton Date signed

Nov 12, 1945

G34077

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. 34077

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address BALTIMORE, MD.
(c) Hospital or institution: University Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 mos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 714 W. Mulberry St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Horace Harris Jackson.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Rosa Lynch Jackson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1, 1893

8. AGE: Years 52 | Months | Days | If less than one day hr. min.

9. Birthplace Chestertown, Maryland
(Town, county, and state)

10. Usual Occupation Porter

11. Industry or business Gas + Electric Co.

FATHER
12. Name Horace Jackson.
13. Birthplace Md.

MOTHER
14. Maiden Name
15. Birthplace Md.

16 (a) Informant Mrs Rosa Jackson.
(b) Address 714 W. Mulberry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 13, 1945 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cem.
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) (Date received by registrar) (b) Huntington Williams, M.D. Registrar

NOV 17 1945
VS 1st

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/7 19 45 at 3:30 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C.V disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature J. R. Lubinski M.D.
Medical Examiner.

Date signed 11/7/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34078

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1318

G34078 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address —
(c) Hospital or institution: 509 N. Bruce Street
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 509 N. Bruce (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Blanche Green

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1920 - 7 - 7

8. AGE: Years 25 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Charles Green.
13. Birthplace Howard County, Md.

MOTHER
14. Maiden Name Mamie Howard
15. Birthplace Howard County, Md.

16 (a) Informant Mamie Green
(b) Address 509 N. Bruce St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 - 12 - '45 (month) (day) (year)
(c) Cemetery or crematory Arlington Memorial
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) NOV 12 1945 by Registrar for Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 8 1945, at 9:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from July 5 1945, to Nov. 8 1945, and that I last saw h[illegible] alive on Nov. 8 1945

Immediate cause of death: Pulmonary Tuberculosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. W. Reckling, M.D.

Address 726 N. Johns Date signed 11/12/45

G34079

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G34079

CHK-96710

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 45- 2- 3-

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 645 W. Mulberry Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Walter Garrison

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 4-1900

8. AGE: Years	Months	Days	If less than one day
45	2	3	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name James Garrison
13. Birthplace Maryland

MOTHER
14. Maiden Name Ida Thomson
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov-13-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R Williams
(b) Address 322 N. Schroeder St

NOV 19 1945 (b) Huntington Williams
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 7 1945, at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 16 1945 to Nov. 7 1945, and that I last saw him alive on Nov. 7 1945.

Immediate cause of death	Duration
Uremia	
a Cerebral Hemorrhage	
Due to Nephrosclerosis & Hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: None
of autopsy: Nephrosclerosis & Cerebral Hem.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature T. P. Jerrigan M. D.
Address Baltimore City Hosp. Date signed 11-9-45

VS 150

G34080

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 33B

G34080 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hosp 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) 26 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 9
(If outside city or town limits, write RURAL and give town)
(d) Street No. 516 Robert St
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Washington Underwood

3 (b) If veteran, name war: World War II
3 (c) Social Security Account No.:
4. Sex: Male
5. Color or race: Negro
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Volquneenia Underwood
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 8-22-1914
8. AGE: Years 26 Months 2 Days 19 If less than one day hr. min.
9. Birthplace Petersburg Virginia
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Robert Washington Underwood,
13. Birthplace Petersburg, Virginia

MOTHER
14. Maiden Name Ruth Simmons
15. Birthplace Virginia

16 (a) Informant Volquneenia Underwood
(b) Address 516 Robert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 14, '45 (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 NOV 12 1945 (b) Huntington Williams M.D.
(Date rec'd by local registrar) (Signature of local registrar)

VS 158

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-10 1945 at 7:29 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-27 1945, to 11-10 1945 and that I last saw h alive on 11-10 1945

	Duration
Immediate cause of death Acute Glomerulo-Nephritis	10 days
Due to Bronchopneumonia	10 days
Due to Influenza	7 days
Other Conditions —	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operations —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. R. Carr M. D.
Address 515 Mosher St Date signed 11-12-45

634081

AB-97012

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

634081

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3days

(e) Length of stay in Baltimore (yrs., mos., or days) 2yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 226 N. Wolfe St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Harry Daye

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Separated

6 (b) Name of husband or wife Blanche

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 23-1920

8. AGE: Years	Months	Days	If less than one day
25	4	29	hr. min.

9. Birthplace N.C.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name John Daye

13. Birthplace N.C.

MOTHER — 14. Maiden Name Senora Southern

15. Birthplace N.C.

16 (a) Informant Baltimore City Hospitals(Record

(b) Address 4940 Eastern Ave.

17 (a) [illegible] (Burial, cremation, or removal) (b) Date thereof Nov. 12, 45 (month) (day) (year)

(c) Cemetery or crematory

Location Raleigh, N. C.

18 (a) Funeral director Mrs Hattie R. Williams

(b) Address 322 N. Schroeder St.

19 (a) (b) [illegible] Registrar

(Date rec'd by registrar) NOV 12 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 2- 19 45, at 5.20P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-31- 19 45 to 11-2- 19 45, and that I last saw h[illegible] alive on 11-2 19 45

Immediate cause of death Pulmonary Tuberculosis — Duration 2.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy: no post

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Herbert L. Opeland Jr.

Address Balt. City Hosp. Date signed 11/6/45

G34082

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 a

Registered No. G34082

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 400 S. Gilmor St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 4
(e) Length of stay in Baltimore (yrs., mos., or days) 41yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 400 S. Gilmor St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Peter Holzinger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M. | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Susanna Geier

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 17, 1880

8. AGE: Years 65 | Months 5 | Days 22 | If less than one day hr. min.

9. Birthplace Hungary (town, county, and state)

10. Usual Occupation Glove Cleaner

11. Industry or business

FATHER 12. Name Peter Holzinger
13. Birthplace Hungary

MOTHER 14. Maiden Name Margaret Krauskopf
15. Birthplace Hungary

16 (a) Informant Peter J. Holzinger
(b) Address 402 S. Gilmor St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/13/45 (month) (day) (year)
(c) Cemetery or crematory New Catholic
Location 3800 Old Frederick Rd

18 (a) Funeral director Harry A. Wilson
(b) Address 4101 Edmondson Ave

19 (a) Dec 13 1945 Received by registrar Hiram Livingston for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 9 1945 at 4 55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 2nd 1945 to Nov. 9th 1945 and that I last saw him alive on Nov. 9th 1945.

Immediate cause of death	Duration
Carcinoma of Oesophagus	3 months
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry Yates

Address 517 Dolphin St, Date signed 11/12/45 M.D.

VS 150

G34083

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93

G34083 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2812 Winchester St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2812 Winchester St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Edward Grimes

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-01-6862

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 16, 1878

8. AGE: Years	Months	Days	If less than one day
67	3	25	hr. min.

9. Birthplace Rockland, Howard Co. Md.
(Town, county, and state)

10. Usual Occupation Coach Painter

11. Industry or Business

FATHER
12. Name Charles H. Grimes
13. Birthplace Rockland, Howard Co. Md.

MOTHER
14. Maiden Name Rovenia R. Clar
15. Birthplace Balto Co. Md.

16 (a) Informant Mrs. Allen G. Fowler
(b) Address 2501 Poplar Drive

17 (a) Burial (b) Date thereof Nov. 13, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Good Shepherd
Location Rockland, Md.

18 (a) Funeral director Easton Sons
(b) Address Ellicott City, Md.

19 (a) NOV 13 1945 (Date received by registrar) (b) Per Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 10, 1945 19 ..., at 8:05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 6 1945 to Nov 10 1945
and that I last saw h mive on Nov 9 1945.

Immediate cause of death	Duration
Mfs Cerebral Hemorrhage	3 days
Due to Rt Sided Hemiplegia	4 days
Due to Hypertension	5 yrs
Other Conditions ✓	

(Include pregnancy within 3 months of death)
Date of operation ✓
Major findings of operation: ✓
of autopsy: ✓

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ✓
(b) Date of occurrence ✓ at M
(c) Where did injury occur? ✓
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ✓ While at work?
(Specify type of place)
(e) Means of injury ✓

23. Signature Howard Kahle
Address 827 N Eutaw St Date signed Nov 13 1945

VS 180

G34084

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G34084

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6648 Eastern ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ~~Balto.~~
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6648 Eastern Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Belle Busse

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	married

6 (b) Name of husband or wife Frederick H Busse.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 4 1881

8. AGE:	Years	Months	Days	If less than one day
	64	7 8	6	hr. min.

9. Birthplace Balto. City.
(Town, county, and state)
10. Usual Occupation at Home
11. Industry or business —

FATHER
12. Name Irving Reynolds
13. Birthplace Balto.

MOTHER
14. Maiden Name Nancy Mills
15. Birthplace Balto.

16 (a) Informant Frederick Busse
(b) Address North Rt Rd.

17 (a) Burial (b) Date thereof 11/14/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave. Rd.

18 (a) Funeral director John D Connelly
(b) Address 418 Eastern Ave. Balto 21

NOV 13 1945 Huntington Williams, M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 10 1945, at 2. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1945 to Nov 10 1945, and that I last saw him alive on Nov 9 1945

Immediate cause of death	Duration
Chronic Interstitial Nephritis	
Due to Hypertension	
Due to Diabetes	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature M. A. Jacobs M. D.
Address 617 North Rt Date signed 11/12/45

G34085

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G34085 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4200 Springdale Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 48 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City ~~or town~~ Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4200 Springdale Ave. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) **FULL NAME** MILLIE R. ROSENBAUM.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband ~~or wife~~ Aaron Rosenbaum

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 13, 1871.

8. AGE: Years 74 | Months 2 | Days 29 | If less than one day hr. min.

9. Birthplace New York. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Aaron Rothschild,
13. Birthplace Germany.

MOTHER
14. Maiden Name Unknown.
15. Birthplace Germany.

16 (a) Informant Mrs. S. K. Solmson,
(b) Address 4200 Springdale Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11.13.45. (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship Cem.
Location Balto. Md.

18 (a) Funeral director Marcus Sonneborn & Son
(b) Address 1902 Eutaw Place.

19 (a) 11 13 1945 (Date rec'd by registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 11th. 1945, at 5.31 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/21 1940 to 11/11 1945, and that I last saw h[illegible] alive on 11/10 1945.

	Duration
Immediate cause of death Coronary occlusion	1 day
Due to Arteriosclerosis	?
Due to Diabetes mellitus	25+ yrs.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank Levenson M. D.
Address 4004 Liberty Heights Ave. Date signed

634086

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

634086 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3415 Clarks Lane (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Irvin H. Kohn (Irving H. Kohn)

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-01-8170

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Rosalie S. [illegible]

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-3-85

8. AGE: Years 59 | Months 11 | Days 8 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Merchant

11. Industry or business

FATHER 12. Name Louis B. Kohn

13. Birthplace Va

MOTHER 14. Maiden Name Leah Klugenstein

15. Birthplace N.Y.

16 (a) Informant Recorder

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Entombment (b) Date thereof 11/13/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery [illegible] Har Sinai
Location Balto. Md.

18 (a) Funeral director Sharrett Funeral Home

(b) Address 1902 Eastern Place

NOV 13 1945 (b) Huntington Williams, M.D.
(Date received by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 11 1945 at 10 a.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 7 1945 to Nov. 11 1945; that I last saw him alive on Nov. 11 1945.

Immediate cause of death — Duration

Heart Failure

Due to Coronary Occlusion — 3 days

Due to Arteriosclerotic Heart Disease — ? 10 yrs

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Laurence Dickson M.D.

Address Johns Hopkins Hosp. Date signed 11/14/45

X

G34087

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 45 ✓

G34087 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard + Green
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30D.
(e) Length of stay in Baltimore (yrs., mos., or days) none

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County Yorke
(c) City or town New Freedom
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Charles G. Summers, Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No. 199-07-3758

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Annie McCurley Summers. 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 29 1871

8. AGE: Years 74 | Months 5 | Days 13 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Executive

11. Industry or business Canning factory.

FATHER 12. Name Chas. G. Summers

13. Birthplace Maryland

MOTHER 14. Maiden Name Mary R. Thomas

15. Birthplace Maryland

16 (a) Informant Son (Chas. G. Summers, Jr.)

(b) Address New Freedom, Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 15, 1945 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge

Location Baltimore, Md.

18 (a) Funeral director Jacob Hartlaub

(b) Address New Freedom, Pa.

19 (a) 11 13 1945 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-12 1945 at 8:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 4 1945 to Oct. 12 1945 and that I last saw him alive on Oct. 12 1945

Immediate cause of death Cardiac failure | Duration

Due to Pneumonia, lobar

Due to CA of lung

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Oct. 10, 1945

Major findings of operation: CA of lung

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. B. Dorsey M. D.

Address Univ. Hosp. Date signed 11-12-45

VS 150

G34088

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G34088

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette W. Baltimore
(c) Hospital or institution Franklin Square Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7d.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. #19 Washburn Ave (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME (Pettit, Joseph) Joseph F. Pettit

3 (b) If married, name wife None

3 (c) Social Security Account No. 24403-4206

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Eunice J. Pettit

6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) July 17-1889

8. AGE: Years	Months	Days	If less than one day
56	3	25	— hr. — min.

9. Birthplace Texas (Town, county, and state)

10. Usual Occupation
11. Industry or business Textile Industry

FATHER
12. Name Unknown
13. Birthplace —

MOTHER
14. Maiden Name Unknown
15. Birthplace —

16 (a) Informant Eunice J. Pettit
(b) Address 19 Washburn Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 14-1945 (month) (day) (year)
(c) Cemetery or crematory
Location Lancaster S. Carolina

18 (a) Funeral director Pratt C. B.M. Walters
(b) Address Pratt & Stockbridge Sts

NOV 13 1945 (Date received by Registrar) Huntington Williams Mgr

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 11 — 1945 at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 19 1945 to Nov 11 1945 and that I last saw him alive on 11-11-1945.

Immediate cause of death Myocarditis

Due to Bronchial Pneumonia

Due to —

Other Conditions Hypertensive Cardiovascular Disease
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leonard Rubenstein M. D.
Address 208 Patapsco Ave Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634089

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

634089 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greenspring + Belvedere Aves
(c) Hospital or institution: Levindale Hebrew Home + Infirmary
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Levindale Home (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Abraham Kramer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Late Pauline

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1868

8. AGE: Years 77 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER 12. Name Unkown

FATHER 13. Birthplace Russia

MOTHER 14. Maiden Name Unkown

MOTHER 15. Birthplace Russia

16 (a) Informant Mrs Sarah Miller

(b) Address 2500 Hollins Ferry Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 13, 1945 (month) (day) (year)

(c) Cemetery or crematory Hebrew Herring Run Cem.

Location Bowleys Lane

18 (a) Funeral director Sol Levinson & Bros

(b) Address 1124-1126 W North Ave

19 (a) [illegible] (b) Registrar Huntington Williams, M.D.

NOV 14 1945

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH November 12 1945, at 10.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-15 1935, to 11-12 1945, and that I last saw h[illegible] alive on 11-12 1945.

Immediate cause of death Chr. end. vascular disease Hypertension.

Duration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Edmund Levin

Address Levindale Date signed 11/13/45

X

G34090

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. G34090

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St. & Rutland Ave.
(c) Hospital or institution:
Sinai Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 4 mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1204 N. Montfred
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME AMELIA CAROLYN RINGSDORF

3 (b) If veteran, name war: none
3 (c) Social Security Account No. none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: none
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) July-13-1945
8. AGE: Years — Months 3 Days 30 If less than one day 29 hr. min.
9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation none
11. Industry or business none

FATHER
12. Name J. Lambert Ringsdorf
13. Birthplace Baltimore

MOTHER
14. Maiden Name Amelia C. Czarnowsky
15. Birthplace Baltimore Md

16 (a) Informant J. L. Ringsdorf (Father)
(b) Address 1204 N Montfred

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 11-14-45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore Md

18 (a) Funeral director: Sullivan Mayer Co.
(b) Address 108 W Mt Royal Ave.

NOV 13 1945 (Date received by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 12, 1945 at 1:45 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 11, 1945 to Nov. 12, 1945 and that I last saw her alive on Nov. 12, 1945.

Immediate cause of death ~~Cardiac failure~~
(a) Bronchopneumonia — Duration ?
Due to (b) Adrenal hemorrhage
Due to (c) Septicemia (?)

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: listed above + pulmonary edema

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Arnold Katz M. D.
Address Sinai Hosp. Balt. Md Date signed 11-12-45

VS 150

G34091

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G34091 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Beech & 40 & Sts -
(c) Hospital or institution: at Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0 1 7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Beech & 40 - Wyman Pk Apts (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Isabelle Clark Wilson

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Thos. J. Wilson
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept-17-1865

8. AGE: Years 80 | Months 1 | Days 24 | If less than one day: hr. 3 min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business —

FATHER
12. Name Thos. S. Clark
13. Birthplace U. S. A.

MOTHER
14. Maiden Name Henrietta Hope
15. Birthplace U. S. A.

16 (a) Informant Mrs. Ray W. Baird daughter
(b) Address Melrose Ave - Phila Pa

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Nov-13-45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Stewart Mortuary Co.
(b) Address 108 W Main St. Westminster Md.

19 NOV 13 1945 (Date rec'd by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 10 1945, at 8.05 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 5 1945, to Nov 10 1945, and that I last saw h[illegible] alive on Nov 10 1945.

Immediate cause of death: Angina Pectoris — Duration: 11/5/45
Due to: Diabetes Mellitus — Duration: ?
Due to: —
Other Conditions: —
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chas D Bubert M. D.
Address 108 Park Heights Ave Date signed 11/12/45

VS 150

G34092

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G34092

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) d. o. a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 327 E. 20th Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John W. Striegle

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex Male | 5 Color or race White | 6 (a) ~~Single~~, married, ~~widowed, or divorced~~. Married

6 (b) Name of ~~husband or~~ wife Mildred M. Striegle

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 25th 1906

8. AGE: Years 39 | Months 4 | Days 17 | If less than one day hr. min.

9. Birthplace Texas (Town, county, and state)

10. Usual Occupation Mechanic

11. Industry or business Decorating

FATHER
12. Name John W. Striegle
13. Birthplace Md.

MOTHER
14. Maiden Name Dottie Davis
15. Birthplace Va.

16 (a) Informant Mildred M. Striegle
(b) Address 2300 Frederick ave.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 11/15/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Western
Location Balto. Md.

18 (a) Funeral director William Doak Inc.
(b) Address 127 St. Paul St

19 NOV 13 1945 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 12, 1945, at 9 M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Stasulis M.D.
Medical Examiner.
Date signed November 13, 1945.

VS 151

Please write age in capitals and fill in all blanks. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34093

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D ✓

Registered No. G34093

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2834 Guilford Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2834 Guilford Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Buckheimer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, ~~married, widowed, or divorced~~
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 18th 1872

8. AGE: Years	Months	Days	If less than one day
73	4	23	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business School Teacher

FATHER
12. Name Peter Buckheimer
13. Birthplace Germany

MOTHER
14. Maiden Name Hannah Butts
15. Birthplace England

16 (a) Informant Mrs. Robt. C. Dorr
(b) Address 2834 Guilford ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/14/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Balto.
Location " Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul st.

19 NOV 13 1945 (Date rec'd by registrar) Livingston Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 11th 1945; at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 14 1945 to Nov 11 1945 and that I last saw h[illegible] alive on Nov 11 1945.

Immediate cause of death	Duration
Cardio - vascular	
hypertension disease	5 yrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Homer A. Dodd M. D.
Address 735 N Fulton Ave Date signed 11/14/45

VS 150

X

G34094

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 16-9

Registered No. G34094

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Hosp. for Women of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) 3

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6 Montrose Ave - 28
(If rural give location)
(e) Citizen of foreign country? U.S. (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Thomas Miller, Jr.

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	Single.

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/10/45

8. AGE: Years	Months	Days	If less than one day
		3	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Charles T. Miller
13. Birthplace Prince Frederick, Md.

MOTHER
14. Maiden Name Anna Celeste Heinz
15. Birthplace Balto. - Md.

16 (a) Informant Charles T. Miller
(b) Address 6 Montrose Ave - Balto. 29.

17 (a) Burial (b) Date thereof 11/14/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn Md.

18 (a) Funeral director Geo L. Berger Jr
(b) Address 1512 Hollins St.

19 (a) NOV 13 1945 (b) Huntington Williams, M.D.
(Local Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/12 1945, at 3.05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/10 1945 to 11/12 1945; and that I last saw h[illegible] alive on 11/12 1945.

Immediate cause of death	Duration
Aspiration of vomitus	
Due to Acute Coma	
Due to Pneumo Encephalography	3 days
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Elizabeth Hetrick, M.D.
Address Hosp. for Women of Md. Date signed 11/12/45

G34095

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G34095 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 748 Pierce St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 748 Pierce St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carrie Gibson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 17, 1892

8. AGE: Years 53 | Months 4 | Days 22 | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name ?

13. Birthplace

MOTHER 14. Maiden Name ?

15. Birthplace

16 (a) Informant Mr. Turner

(b) Address 712 Brune St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-14-45 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location

18 (a) Funeral director Adolphus Halstead

(b) Address 918 Druid Hill Ave.

19 (a) (Date rec'd by Registrar) (b) Registrar

NOV 13 1945

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 10, 1945, at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 8 1945 to Nov 10 1945 and that I last saw h[illegible] alive on Nov 10 1945.

Immediate cause of death: Cerebral hemorrhage — Duration 2 d

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]

Address 75[illegible] Date signed 11-24-45 M. D.

G34096

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G34096

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1620 Latrobe St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Susie Frazier

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-27-80

8. AGE: Years	Months	Days	If less than one day
65	7	15	hr. min.

9. Birthplace W Va (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name Joseph Freeman
13. Birthplace W Va.

MOTHER
14. Maiden Name Maria Waldon
15. Birthplace W. Va.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 16- (month) (day) (year)
(c) Cemetery or crematory Alderson
Location West Virginia

18 (a) Funeral director James Adams
(b) Address 142 W. Odell St.

NOV 13 1945 (b) Huntington, West Virginia
Date received (Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Wed. 11 1945 at 1:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 8 1945 to Nov 11 1945, and that I last saw her alive on Nov 11 1945

Immediate cause of death	Duration
Respiratory failure	
Due to Bronchopneumonia	3 da
Due to Cerebrovascular accident	
Other Conditions Hypertensive Cardiovascular disease	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William J. Dixon
Address Johns Hopkins Hospital Date signed 11/12/45

X

G34097

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G34097
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital 2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 118 S. Washington Street
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mildred Anna Firnstein

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-22-8140

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or ~~wife~~ Michael Firnstein
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 10, 1914

8. AGE: Years	Months	Days	If less than one day
31 yrs.	4	-	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business Monitor Control

FATHER
12. Name Thomas J. Ticha
13. Birthplace Czechoslovakia

MOTHER
14. Maiden Name Elenor Vojik
15. Birthplace Czechsolovakia

16 (a) Informant Michael Firnstein - Husband
(b) Address 118 S. Washington Street

17 (a) Burial (b) Date thereof 11/14/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or ~~crematory~~ Holy Redeemer
Location Belair Rd. Balto. Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

NOV 13 1945
(Date rec'd by registrar)

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-10 1945, at 9:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 10 1945, to Nov. 10 1945, and that I last saw her alive on Nov. 10 1945.

Immediate cause of death	Duration
Subarachnoid Hemorrhage	
Due to Hypertensive C-V Disease	
Due to	
Other Conditions Myocardial fibrosis Pulmonary edema	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Irene P. Darlow, M.D.
Address Sinai Hospital Date signed 11-10-45

VS 150

Form ~~G.C.~~ Schimunek, By Howard S. Greene, M.D.

G34098 Priet

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1270

G34098 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3114 Donnell Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dorothie E. Priet

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	married

6 (b) Name of husband or wife John J. Priet
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 13 1916

8. AGE: Years	Months	Days	If less than one day
29	2	29	hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business Brukiewa

MOTHER / FATHER
12. Name James F. Brukiewa
13. Birthplace Cieslak
14. Maiden Name Ida Cieslak
15. Birthplace Poland

16 (a) Informant Mrs. John J. Priet
(b) Address 3114 Donnell Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 16 45 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart of Mary
Location German Hill road

18 (a) Funeral director Stuptan Funeral Home
(b) Address 800 S. Linwood Ave

19 NOV 13 1945 (Date rec'd by Reg.) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/12 1945, at 12 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/7 1945 to 11/12 1945 and that I last saw h[illegible] alive on 11/12 1945.

Immediate cause of death
Pneumonia
Post operative
Due to

Due to

Other Conditions Cholecystitis
(Include pregnancy within 3 months of death)
Date of operation 11/8/45
Major findings of operation: Cholecystitis
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hubert Jamison M. D.
Address 1 W. Pratt St Date signed 11/12/45

VS 150

G34099

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

Registered No. G34099

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 326 N. Carey St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days) 25yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 326 N. Carey St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

3 (a) FULL NAME Charles Linwood Blue (Bleue)

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
No	213-07-5130	M	C	Married

6 (b) Name of husband or wife Ethel
6 (c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) 8/13/1903

8. AGE: Years	Months	Days	If less than one day
42	2	27	hr. min.

9. Birthplace Farmville, Va.
(Town, county, and state)
10. Usual Occupation Steel Worker
11. Industry or business

FATHER
12. Name Charles Blue
13. Birthplace Farmville, Va

MOTHER
14. Maiden Name Mary Mason
15. Birthplace Farmville Va.

16 (a) Informant Ethel Blue (Wife)
(b) Address 326 N. Carey St.

17 (a) Burial (b) Date thereof 11/14/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Farmville
Location Farmville, Va.

18 (a) Funeral director Charles G. Cooper
(b) Address 512 N. Carrollton Ave

NOV 13 1945 (b) Huntington Williams M.D.
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/10/45 19..... at 3 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1945 to Nov 10-1945 and that I last saw him alive on November 10-45

Immediate cause of death: Mitral Insufficiency — Duration 6 months

Due to.....

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operation:.....

.....

of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....

23. Signature J. H. Thomas
Address 107 N. Main St Blandale 20 Md Date signed 11/13/45

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34100

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G34100 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1934 St Paul St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1934 St Paul St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Cassandra Creamer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 29 - 1858

8. AGE: Years 86 | Months 11 | Days 17 | If less than one day hr. 12 min.

9. Birthplace Baltimore Md (City, county, and state)

10. Usual Occupation Retired

11. Industry or business None

FATHER
12. Name Wm W Bell
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Sarah Randell
15. Birthplace Long Green Md

16 (a) Informant Mrs L King
(b) Address 3201 Ruskin Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 14 - 45 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem
Location

18 (a) Funeral director Charles P Powell
(b) Address 2427 Edmondson Ave

19 (a) (Date received by Registrar) (b) Registrar

NOV 13 1945 Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 11 1945 at 6 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1945 to Nov 11 1945 and that I last saw her alive on Nov 11 1945.

	Duration
Immediate cause of death Coronary Artery Art. Sclerosis,	
Due to Myocardial Infarction	10d
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Carroll Packard M. D.
Address 2925 N. Charles St Date signed Nov 45

X

G34101

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G34101
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 224 Woodlawn Rd. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) **FULL NAME** John Moseley Walker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mrs. J. M. Walker
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Nov 19, 1862

8. AGE: Years	Months	Days	If less than one day
82	11	21	..... hr. ..... min.

9. Birthplace North Carolina (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name John M Walker
13. Birthplace N. Carolina

MOTHER
14. Maiden Name Mary Gibbs
15. Birthplace N. Carolina

16 (a) Informant Hospital Record
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 13/45 (month) (day) (year)
(c) Cemetery or crematory St Thomas
Location Garrison Forest Md

18 (a) Funeral director Henry R. Eastman Funeral Home
(b) Address McCulloh & Orchard Sts

19 (a) ..... (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 19 NOV 13 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH November 10 1945, at 10:35 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 10 1945 to Nov. 10 1945 and that I last saw him alive on Nov. 10 1945.

Immediate cause of death	Duration
Broncho-pneumonia	5 days
Due to Arteriosclerotic heart disease with decompensation	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. H. Sweet III M. D.
Address Union Memorial Hospital Date signed 11-10-45

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634102

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registration No. 634102

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 3908 N Charles St
(b) Street address Washington apts
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) 36 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3908 N. Charles St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Georgianna Mayo Bailliere

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Laurence Bailliere
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Mar. 8 - 1868
8. AGE: Years 80 | Months 0 | Days 4 | If less than one day ... hr. ... min.
9. Birthplace Baltimore - Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Thos. H. Gaither
13. Birthplace Baltimore - Md

MOTHER
14. Maiden Name Sophia Bland Mayo
15. Birthplace Annapolis - Md -

16 (a) Informant Thos. H. G. Bailliere
(b) Address Warrington apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 14 19 (month) (day) (year)
(c) Cemetery or crematory St John
Location Ellicott City Md
18 (a) Funeral director Henry Nicholson & Sons Co
(b) Address McCulloh & Orchard Sts
19 (a) ... (Date rec'd by registrar) (b) ... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-12 1945, at 6:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/15 1934 to 11/12 1945 and that I last saw her alive on 11/12 1945

Immediate cause of death: Complete Heart Block
Incomplete Heart Block — Duration: 3 day
Due to: Arterio-Sclerotic — 5 years
myocardial degeneration
Due to:
Other Conditions: Status-Adams Syndrome
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Chas. C. Guild M. D.
Address 2 E Wendover Road Baltimore 18, Md. Date signed 11-13-45

VS 150

NOV 13 1945

G34103 ✓ G34103

BALTIMORE CITY HEALTH DEPARTMENT

G34103 CERTIFICATE OF DEATH 48B Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1712 Lancaster St
(c) Hospital or institution:
Home ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, 31.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1712 Lancaster Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frances Agnes Rozga
Frances Marski (Or) Frances Wienecki

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-01-1608

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	?

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 9th, 1887?

8. AGE: Years	Months	Days	If less than one day
58?	8	3	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Walenty Rozga
13. Birthplace Poland

MOTHER
14. Maiden Name Maryanna Novak
15. Birthplace Poland

16 (a) Informant Mrs. Mary Rozga (Mother)
(b) Address 1712 Lancaster Street

17 (a) Burial (b) Date thereof 11-15-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory ST. STANISLAUS
Location BALTIMORE, Md

18 (a) Funeral director George A Weber
(b) Address 705 S Grim st

19 (a) (b)
(Date received by registrar) Registrar

VS NOV 13 1945 Huntington Hollins, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 12th 1945, at 8.30 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1945 to Nov 12 1945, and that I last saw h[illegible] alive on Nov 12 1945

Immediate cause of death Hypostatic Pneumonia — Duration 11/10/45

Due to Carcinoma of Uterus — 2/1945

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William J. Groark M. D.
Address 801 Keswick Rd Date signed 11/13/45

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34104

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G34104

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4414 Marx Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4414 Marx ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Agostino Di Pane

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife Carolina Vetri

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 22-1862

8. AGE: Years	Months	Days	If less than one day
83	2	20	hr. min.

9. Birthplace Italy
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Antonio Di Pane
13. Birthplace Italy

MOTHER
14. Maiden Name Francesca Rizzo
15. Birthplace Italy

16 (a) Informant Frances M. Di Pane
(b) Address 4414 Marx ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 14-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Frank V. Pipitone
(b) Address 281 E. Baltimore st

19 (a) (Date received by Registrar) (b) Registrar

NOV 13 1945

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 11th 1945, at 10:50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 1943 to November 11 1945, and that I last saw h[illegible] alive on Nov. 11 1945.

Immediate cause of death	Duration
Coronary Thrombosis	40 minutes
Due to Generalized arteriosclerosis	10 yrs.?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature S. Falcon M. D.
Address 6217 Harford Rd Date signed 11/12/45

VS 180

SA Blessi X

G34105

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1190

Registered No. G34105

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 9 months

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1118 Brevard St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ernest Lee Grant

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan. 26, 1945

8. AGE: Years | Months: 9 | Days: 14 | If less than one day: hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER — 12. Name Archie Grant
13. Birthplace S. C.

MOTHER — 14. Maiden Name Julia ?
15. Birthplace S. C.

16 (a) Informant Archie Grant
(b) Address 1118 Brevard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 13 45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore Md

18 (a) Funeral director Gilliam & Jackson
(b) Address 916 Pennsylvania Ave

NOV 13 1945 (Date filed by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-11 1945, at 8:05 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-3 1945, to 11-11 1945, and that I last saw h/m alive on 11-11 1945.

Immediate cause of death Dehydration — Duration: 12 days (Hinton)

Due to vomiting and diarrhea

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. R. Bruffell M. D.
Address 718 Dolphin St. Date signed 11-13-45

VS 150

G34106

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 62B

G34106 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Monument St
(c) Hospital or institution: Sinai Hospt
(d) Length of stay in hospital or inst. (yrs., mos., or days): 13d
(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md (b) County:
(c) City or town: Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 1626 Gwynns Falls Pkwy
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country:

3 (a) FULL NAME: Mrs. Rose Ulitzky

3 (b) If veteran, name war: —

3 (c) Social Security Account No.: —

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Samuel

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1872

8. AGE: Years: 73 | Months: | Days: | If less than one day: hr. min.

9. Birthplace: Russia (Town, county, and state)

10. Usual Occupation: None

11. Industry or business:

FATHER
12. Name: Abraham
13. Birthplace: Russia

MOTHER
14. Maiden Name: Tilda
15. Birthplace: Russia

16 (a) Informant: Hospt Records
(b) Address:

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory: Mt Carmel
Location: Old German Rd Balto

18 (a) Funeral director: Jack Levy Inc
(b) Address: 1429 E. Balto St

19 (a) (Date rec'd by registrar) (b) Huntington Williams, Registrar

NOV 13 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11-13 1945, at 4:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-12 1945 to 11-13 1945, and that I last saw her alive on 11-13 1945.

Immediate cause of death	Duration
Thyrotoxic Heart Disease	2-3 years
Due to Toxic Adenoma of Thyroid	3 yrs.
Due to Chronic Congestive Failure & Auric. Fibrillation	2 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation: —
of autopsy: — none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Arnall Katz M. D.
Address: Sinai Hosp Balt Md Date signed: 11-13-45

G34107

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH (93)

Registered No. G34107

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1407 W. Lexington St
(c) Hospital or institution: Aged Home.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1407 W. Lexington St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jennie B. Miller.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. widow.

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 23 1856

8. AGE: Years 89 | Months 7 | Days 20 | If less than one day hr. min.

9. Birthplace New Oxford Pa. (Town, county, and state)

10. Usual Occupation None.

11. Industry or business

FATHER
12. Name Uriah Baughman.
13. Birthplace Pa.

MOTHER
14. Maiden Name Catherine Fleshinger.
15. Birthplace Pa.

16 (a) Informant Euter Funeral Home
(b) Address York Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 15/45 (month) (day) (year)
(c) Cemetery or crematory York, Pa
Location

18 (a) Funeral director Ehrenwerth & Donovan
(b) Address 315-17 Chestnut Ave.

19 NOV 18 1945 (b) Huntington Wilhelm M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 12, 1945, at 10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/23/ 1929 to 11/12/ 1945 and that I last saw h. or alive on 11/11/ 1945

	Duration
Immediate cause of death: Cerebral hemorrhage, 1t.	10/11/45
Due to: Hypertensive cardio-vascular disease	1 yrs.
Due to:	
Other Conditions:	
(Include pregnancy within 3 months of death)	
Date of operation:	
Major findings of operation:	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edwin B. Jarrell. M. D.
Address 11 E. Chase St., City Date signed 11/13/45

VS 150

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. TYPEWRITE WHERE POSSIBLE, WITH UNFADING INK.

G34108

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 193D

G34108 Registered No.

correct age is especially important. Physicians: please write the ... to the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1029 Stockton Balto md
(c) Hospital or institution: 16

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County Balto
(c) City or town Balto md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1029 Stockton
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Fannie Brockenbrough or Brockman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Col	Single

6 (b) Name of husband or wife no

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 18 1881

8. AGE: Years	Months	Days	If less than one day
63 6 14	10	23	hr. min.

9. Birthplace Essex Co Va
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name John Brockenbrough
13. Birthplace Essex Va

MOTHER
14. Maiden Name Mollie Young
15. Birthplace Essex Co Va

16 (a) Informant Bessie Corbin
(b) Address 1309 Gilmor

17 (a) Burial (b) Date thereof Nov 14/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Brooklyn

18 (a) Funeral director Wm Brooks
(b) Address 1463 N. Carey St

19 (a) (b) Registrar
(Date rec'd by registrar)
NOV 13 1945 Huntington Hilliard

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-11-45 19 at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/9/45 19 to 11/11-1945 and that I last saw h[illegible] alive on 11/10/45.

Immediate cause of death Cerebral Hemorrhage — Duration

Due to Myocarditis

Due to Fatty Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at A M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 1135 Gilmor Date signed 11/13/45

G34109

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G34109 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1 W. Franklin Street
(c) Hospital or institution: 4

(d) Length of stay in hospital or inst. (yrs., mos., or days) ----
(e) Length of stay in Baltimore (yrs., mos., or days) 67 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County --------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1 W. Franklin Street
(If rural give location)
(e) Citizen of foreign country? -------- (Yes or No)
If yes, name country --------

3 (a) FULL NAME Edward A. O'Mara

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Ferolene H. Nitsch
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) -------- 1878

8. AGE: Years	Months	Days	If less than one day
67	---	---	-- hr. --- min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Lawyer
11. Industry or business --------

FATHER
12. Name Edward O'Mara
13. Birthplace Ireland

MOTHER
14. Maiden Name Honorah Fitzgerald
15. Birthplace Ireland

16 (a) Informant Mrs. F. H. O'Mara
(b) Address 1 W. Franklin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/14/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Mears and Son
(b) Address 805 N. Calvert Street

19 (a) ---- (Date rec'd by registrar) (b) ---- Registrar

NOV 13 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 11 1945 at 5 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 9 1945 to 11/14/45 1945. and that I last saw him alive on 11/11 1945.

Immediate cause of death	Duration
Cerebral arteriosclerosis	3 yrs.
Cardiac decompensation	
Due to Chronic nephritis.	8 yrs.
Due to acute pulmonary edema	8 hrs.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation ----
Major findings of operation: ----
of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at ---- M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature John F. Mara M. D.
Address 804 Cathedral St Date signed 11/12/45

X

G34110

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. G34110

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Md. General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1606 Llewellyn Ave (If rural give location)
(e) Citizen of foreign country? Llewellyn (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph B Harmon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife SARAH A SHIPLEY

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 23 - 1886

8. AGE: Years	Months	Days	If less than one day
59	8	17	hr. min.

9. Birthplace Richmond Va (Town, county, and state)

10. Usual Occupation Painter

11. Industry or business

FATHER
12. Name Walter Harmon
13. Birthplace Richmond Va

MOTHER
14. Maiden Name Lelia F. Manning
15. Birthplace Richmond Va

16 (a) Informant Edward J. Harmon
(b) Address 1501 Rutland ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/14/45 (month) (day) (year)
(c) Cemetery or crematory Maryland Mem
Location Taylor ave

18 (a) Funeral director Clarence F Hoffman
(b) Address 1639 N Broadway

NOV 13 1945 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 10 1945, at 0 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Septicemia, cellulitis of leg, right

Due to Dog bite of leg

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury Oct. 18 1945 8/6 45 8 P M.
(b) Where did injury occur? In front of 1616 N. Broadway
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no
(d) Means of injury Bitten by dog

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed Nov. 11 1945

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34111 5 BALTIMORE CITY HEALTH DEPARTMENT G34111

CERTIFICATE OF DEATH 4186a

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sanai Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 47 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 314 S. Ann Street (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME ALEXANDER GRYGLIK Aleksander Gryglik
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. married
6 (b) Name of husband or wife Rose Gryglik
6 (c) If alive, give age 63 years
7. Birth date of deceased (mo., day, yr.) 1877
8. AGE: Years 68 | Months | Days | If less than one day hr. min.
9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business
FATHER 12. Name Joseph Gryglik
13. Birthplace Poland
MOTHER 14. Maiden Name Mary Terepka
15. Birthplace poland
16 (a) Informant Mrs. Rose Gryglik
(b) Address 314 S. Ann Street
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 (month) 14 (day) 45 (year)
(c) Cemetery or crematory Holy Rosary cem. Location Baltimore County
18 (a) Funeral director John J. Weber
(b) Address 401 S. Chester Street
19 (a) (b) Huntington Williams, M.D. Registrar
Date rec'd by registrar NOV 13 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-10 1945 at 5 55 A.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 10-29 1945 to 11-10 1945 and that I last saw him alive on 11-10 1945.

Immediate cause of death	Duration
Subarachnoid hemorr., laceration of brain, fractured skull	
Due to Trauma trauma	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Autopsy performed

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes fill in the following: 2/2
(a) Accident, suicide, or homicide accident
(b) Date of occurrence 10-29-45 at M
(c) Where did injury occur? 314 S. Ann Street (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home. While at work? No. (Specify type of place)
(e) Means of injury Fell down the stairs.
23. Signature Daniel Hamburger M. D.
Address Sinai Hospital Date signed 11-13-45
Benedict Skotarski) M. D.

VS 150

G34112

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

G34112 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1407 McHenry St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1407 McHenry St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine E. Kestler

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F.

5. Color or race W.

6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife John J. Kestler

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, year) Jan. 28 1871

8. AGE: Years 74 Months 9 Days 13 If less than one day hr. min.

9. Birthplace Columbia, Pa. (Town, county, and state)

10. Usual Occupation Home Duties

11. Industry or business

FATHER
12. Name John Young
13. Birthplace Unknown

MOTHER
14. Maiden Name Harriett Unknown
15. Birthplace Unknown

16 (a) Informant Mrs. Catherine Kestler

(b) Address 1407 McHenry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 14 1945 (month) (day) (year)

(c) Cemetery or crematory London Park

Location Baltimore, Md.

18 (a) Funeral director Frederick A. Dole

(b) Address 1206 W. Lombard St.

19 (a) NOV 13 1945 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 11 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1945, to Nov 11 1945, and that I last saw h[illegible] alive on Nov 11 1945.

Immediate cause of death (Disorder Nutrition) Exhaustion Duration

Due to Hypertension

Due to Arteriosclerosis

Other Conditions Pulmonary Oedema

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Herbert C. Kestler

Address 151 W. Madison Date signed 11/12/45 M. D.

PHYSICIAN

Underline the cause to which death should be charged statistically.

VS 150

X

THESE WHITE BLANKS, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

G34113

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

G34113 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rutherford & Raynor
(c) Hospital or institution WBYH
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 4719 Park Heights Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katie Astrin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Myers

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1893

8. AGE: Years 52 | Months | Days | If less than one day hr. min.

9. Birthplace Wilmington Del (Town, county, and state)

10. Usual Occupation Hosiery Worker

11. Industry or business

FATHER 12. Name Barney Goldstein

13. Birthplace Russia

MOTHER 14. Maiden Name Rebecca

15. Birthplace Russia

16 (a) Informant Myer Astrin

(b) Address 4719 Park Heights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-14-45 (month) (day) (year)

(c) Cemetery or crematory Loredale

Location Phila Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc

(b) Address 1429 E Balto St

19 (a) (b) (Signature of registrar) Registrar

NOV 13 1945 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 12 1945 at 1218 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/8 1945 to Nov 12 1945, and that I last saw her alive on Nov 12 1945

Immediate cause of death: Cerebral Thrombosis — Duration

Due to: Hypertensive CV disease

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: Perforated effusion

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ruth W Baldwin M.D.

Address WBYH. Date signed 11/12

X

G34114

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G34114 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution: Maryland General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 4810 Laurel Ave
(If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William H. Yeatman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 3, 1886

8. AGE: Years	Months	Days	If less than one day
59	4	7	hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name William H. Yeatman
13. Birthplace -

MOTHER
14. Maiden Name Alice M.
15. Birthplace

16 (a) Informant Miss Lillian Yeatman
(b) Address 211 Allendale St.

17 (a) Burial (b) Date thereof 11/13/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 13 1945 (Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/10 1945, at 4 55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/24 1945 to 11/10 1945 and that I last saw him alive on 11/10 1945

Immediate cause of death Pulmonary Edema — Duration

Due to Congestive Heart Failure

Due to Hypertension C.V. Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Martin E. Stuart M. D.

Address Jud. Gen'l. Hospital Date signed 11/10/45

X

G34115

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G34115
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2811 Woodbrook Ave.
(c) Hospital or institution:

131

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(b) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2811 Woodbrook Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MAUD ALICE ALDER

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Daniel S. Alder
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 23, 1875

8. AGE: Years	Months	Days	If less than one day
70	2	19	hr. min.

9. Birthplace Marblehill, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Jacob Mordew
13. Birthplace Md.

MOTHER
14. Maiden Name Rebecca Hartranft
15. Birthplace Pa.

16 (a) Informant Mr. Newton M. Alder
(b) Address 410 North Bend Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/15/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

NOV 13 1945 (Date received by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION P.

20. DATE OF DEATH 11/12/ 1945, at 8:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1945 to Present 19, and that I last saw her alive on Nov. 12 1945.

Immediate cause of death Arteriosclerotic renal disease — Duration many years

Due to Cereal arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. C. Schmidt M. D.
Address 2924 Brighton St. Date signed 11-13-45

X

G34116

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

G34116 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1505 Kensett St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1505 Kensett St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BARBARA B. DONOHUE

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Michael Donohue
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 17, 1869

8. AGE: Years	Months	Days	If less than one day
76	0	24	hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name ? Apple
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs. Jeannette Lefkowitz
(b) Address 1505 Kensett St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/14/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 13 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 11, 1945 at 6:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1944 to Nov. 11 1945
and that I last saw h alive on Nov. 10, 1945

Immediate cause of death	Duration
Myocardial Insufficiency	1 day
Due to Arteriosclerosis	
Due to	
Other Conditions Gastric Carcinoma	

(Include pregnancy within 3 months of death)
Date of operation ✓
Major findings of operation: ✓
of autopsy: ✓

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Silvio D. Levy M.D.
Address 23 E Eutaw Place Date signed 11/12/45

X

G34117 G34117

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1936

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Mahrain & Smith
(c) Hospital or institution: Md. Gen. Hosp. 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 days
(e) Length of stay in Baltimore (yrs., mos., or days) 54 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2611 Garrison Blvd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BRYAN HOLT

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Grace V. Holt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 14, 1888

8. AGE: Years	Months	Days	If less than one day
56	10	28	hr. min.

9. Birthplace Suffolk, Va.
(Town, county, and state)
10. Usual Occupation Chief Clerk (retired 8 mos.)
11. Industry or business B. & O. R. R.

FATHER
12. Name George T. Holt
13. Birthplace Balto.

MOTHER
14. Maiden Name Helen E. Miller
15. Birthplace Galena, Md.

16 (a) Informant Mrs. Grace V. Holt
(b) Address 2611 Garrison Blvd.

17 (a) Burial (b) Date thereof 11/15/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 19 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 14 1945, at 8:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 13 1945 to Nov 12 1945
and that I last saw h. alive on Nov 13 1945.

Immediate cause of death	Duration
Anemia & Congestive heart failure	
Due to Generalized atherosclerosis with hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. M. Candler M. D.
Address Maryland Gen. Hosp. Date signed 11-13-45

VS 150

G34118

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. G34118

PRINT WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5513 Fernpark Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days) 7 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town Philadelphia
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1516 Grange St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) FULL NAME Lura Empson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife James H. Empson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 10, 1863

8. AGE: Years	Months	Days	If less than one day
82	10	2	hr. min.

9. Birthplace Iowa
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name William Walkup
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Elita Hanna
15. Birthplace Pennsylvania

16 (a) Informant Mrs. H. H. Brosius
(b) Address 5513 Fernpark Ave.

17 (a) Burial (b) Date thereof Nov. 15, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount Cemetery
Location Philadelphia, Pa.

18 (a) Funeral director Wm. H. Gillis Lanahan
(b) Address 4510 Liberty Heights Ave.

19 (a) (Registrar) (b) Registrar

NOV 16 1945

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH November 12 1945, at 8.30P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1945 to 1945, and that I last saw her alive on July 1945.

Immediate cause of death	Duration
Coronary thrombosis	
Due to Cerebral thrombosis of the coronary artery	
Due to	
Other Conditions Generalized arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature KURT LEVY, M.D.
Lafayette 0373—Baltimore 17, Md. M. D.
Address 2301 Eutaw Place Date signed

Hugh A. McNally M.D. pro tem

G34119

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 82

Registered No. G34119

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1211 Light St.
(c) Hospital or institution: South Balto Gen. Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Randallstown
(If outside city or town limits, write RURAL and give town)
(d) Street No. Liberty Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MISS. ANNIE C. HAGENRATER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/13, 1873

8. AGE: Years	Months	Days	If less than one day
72	-	29	hr. min.

9. Birthplace Randallstown, Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Henry Hagenrater
13. Birthplace United States

MOTHER
14. Maiden Name Katie Spealman
15. Birthplace Randallstown Md.

16 (a) Informant Mr. John Hagenrater
(b) Address Randallstown, Md.

17 (a) Burial (b) Date thereof Nov. 15, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olive Cemetery
Location Randallstown, Md.

18 (a) Funeral director J. Kelly Lamoreau
(b) Address 4510 Liberty Heights Ave.

19 (a) NOV 13 1945 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 12 1945, at 11.30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 5 1945 to Nov 12 1945 and that I last saw him alive on Nov 12 1945

Immediate cause of death Respiratory Failure — Duration 9 days

Due to Hematomyelia L V Upper Cervical Spinal Cord

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: A. None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John M. Blenn III M.D.
Address South B. Gen. Date signed 11/12/45

Hugh B. McEnaney per BB

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34120

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170c

Registered No. G34120

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7/a hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3015 Monument ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Daniel William Grayson

3 (b) If veteran, name war —

3 (c) Social Security Account No. 212-R-2957

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Negro	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 11, 1901

8. AGE: Years	Months	Days	If less than one day
44	7 mo	29	hr. min.

9. Birthplace Forest Hill Va.
(Town, county, and state)

10. Usual Occupation Stevedore

11. Industry or business

FATHER
12. Name William Lee Grayson
13. Birthplace Forest Hill Va

MOTHER
14. Maiden Name Hattie Darcusshire
15. Birthplace Va.

16 (a) Informant Araunstyglia Thy Secty
(b) Address 1401 Jefferson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 14, 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Peter L. Cowgill
(b) Address 804 N. Carlisle St.

19 NOV 13 1945 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-10- 1945, at 5 A M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured skull

Due to

Other Conditions Multiple fractures.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-9-45 at 10 P.M.
(b) Where did injury occur? Elm. Mc Elroy Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian struck by automobile

23. Signature Howard J. Weaver M.D.
Medical Examiner.
Date signed 11-10-45

VS 151

Give age if legitimate. Physicians: please write the causes of death clearly and legibly.

634121

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1945

Registered No. 634121

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2803 Garrison Blvd.
(c) Hospital or institution:
Prout Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mo.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Rural, Westminster
(If outside city or town limits, write RURAL and give town)
(d) Street No. N. Center St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANCES WHITE SCOTT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	WHITE	Widowed

6 (b) Name of husband or wife John Reed Scott
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years	Months	Days	If less than one day
75	?	?	hr. min.

9. Birthplace Liberty Township, Adams Co. Pa
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name William Ross Everett White
13. Birthplace Penna.

MOTHER
14. Maiden Name Annie Horner
15. Birthplace Penna.

16 (a) Informant Judge F. Neale Parke
(b) Address Court St. Westminster Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/15/45 (month) (day) (year)
(c) Cemetery or crematory Citizens Cemetery
Location Gettysburg, Penna.

18 (a) Funeral director J. E. Myers, Jr.
(b) Address Westminster, Md.

19 NOV 13 1945 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 13, 1945 at 3:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 9, 1945 to Nov. 13, 1945 and that I last saw her alive on Nov. 11, 1945.

Immediate cause of death	Duration
Myocarditis about	2 mo.
Due to Advanced arteriosclerosis - ?	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles Dublett M. D.
Address 2220 Garrison Blvd Date signed 11/13/45

VS 150

FOR BEST RESULTS, WRITE WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34122

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1164c

Registered No. G34122

Type or use ink. Spell out all words; do not use abbreviations. Give exact street address or location. If not in hospital or institution, give usual residence. If born outside U.S., give country instead of state or county. Fill in all items if possible. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West. Baltimore General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3408 Hayward Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James B. Slack

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Goldie E. Slack
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): Jan 16 1890
8. AGE: Years 55 Months 9 Days 26 If less than one day: hr. min.
9. Birthplace Pikesville Balto Co. Md (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business

FATHER
12. Name Harry Slack
13. Birthplace Balto Co. Md

MOTHER
14. Maiden Name Sophia L. Lloyd
15. Birthplace Balto Co. Md

16 (a) Informant Mrs Goldie E. Slack
(b) Address 3408 Hayward Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-14-45 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cemetery
Location Woodlawn, Md.

18 (a) Funeral director Loring Byers
(b) Address 5005 Park Heights Ave

19 NOV 13 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 12 1945, at 2:40 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Gunshot wound
7th Rint

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury November 12, 1945 M.
(b) Where did injury occur? 3408 Haywood Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? at home While at work? no
(d) Means of injury Shot self with shot gun

23. Signature Robert H. Fortune M.D. Medical Examiner.
Date signed 11-13-45

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34123

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

G34123 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1340 Division St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1340 Division St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Florence Clark

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widow

6 (b) Name of husband or wife unknown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 14, 1890

8. AGE: Years	Months	Days	If less than one day
55 ?	9	27	hr. min.

9. Birthplace Roanoke City Md.
(Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name Dennis Mitchell
13. Birthplace Md.

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Corrine Roberts Yeatis
(b) Address 335 Druid Lake Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11/14/45 (month) (day) (year)
(c) Cemetery or crematory
Location Roanoke City Md.

18 (a) Funeral director Mrs. Robert A. Wheeler Dept
(b) Address 1299 N. Caroline St.

19 (a) NOV 13 1945 (Date received by Registrar) Remaining for Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-11 1945, at 5 o'clock P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1945 to 19
and that I last saw alive on 19

Immediate cause of death: Coronary occlusion

Due to: Hardening of arteries

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M Eisenberg M. D.
Address 803 E. Fayette Date signed

G34124

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

Registered No. G34124

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 251 N. Bruce St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 251 N. Bruce St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elva L. Robinson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race C.

6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1904

8. AGE: Years 41 | Months | Days | If less than one day hr. min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Abraham Braddock
13. Birthplace Maryland

MOTHER
14. Maiden Name Annie Powell
15. Birthplace Maryland

16 (a) Informant Mrs Ida Colvin
(b) Address 251 N. Bruce St

17 (a) Burial (b) Date thereof 11-13-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Chas O. Wilson
(b) Address 1000 Brantly Rd

NOV 13 1945 (Date received by registrar) (b) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 9 1945, at 8:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Edema

Due to Cardiac hypertrophy & dilatation

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Forbush M.D.
Medical Examiner.
Date signed Nov. 10 1945

If cause of death clearly and legibly. Physicians: please write the cause of death clearly and legibly. If age is especially important, [illegible]

G34125

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G34125

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution: So. Balto. Gen. Hosp. 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 412 E Gittings St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mary Grace Dillehunt

3 (b) If veteran, name war W | 3 (c) Social Security Account No. W

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife George H Dillehunt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-24-1877

8. AGE: Years	Months	Days	If less than one day
68	4	18	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John F. Bookhultz
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary Taylor
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Grace Simmons
(b) Address 412 E Gittings

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 15, 1945 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Balto Cemetery

18 (a) Funeral director A. Howard Evans
(b) Address 1400 N Charles St

(a) Date received NOV 16 1945 (b) Registrar Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 12 1945; at 1:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 13 1945 to Nov. 12 1945 and that I last saw h.E.R. alive on Nov. 12 1945

Immediate cause of death	Duration
Bronchio-pneumonia	
Due to Hemostasis	
Due to	
Other Conditions Arteria-sclerotic cardio-vascular disease	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph S. Ardinger
Address 1213 Light St Date signed 11-12-45

Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

G34126

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1860

G34126 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Md. Gen. Hos
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 weeks
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. Roland Park Apts (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jenny Finch Lippy

3 (b) If veteran, name war: no
3 (c) Social Security Account No. no

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 30. 1861

8. AGE: Years 84 | Months 6 | Days 12 | If less than one day hr. min.

9. Birthplace Balto - (Town, county and state)

10. Usual Occupation Home duties

11. Industry or business

FATHER
12. Name John Finch
13. Birthplace Balto.

MOTHER
14. Maiden Name Elizabeth Cummings
15. Birthplace Balto.

16 (a) Informant Ida S. Hughes
(b) Address Roland Park Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 13/45 (month) (day) (year)
(c) Cemetery or crematory Balto Cem.
Location E. end of South ave

18 (a) Funeral director John C. Mitchell Sons
(b) Address 1918 Eutaw Place

19 (a) NOV 13 1945 (b)
(Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/11 1945 at 9:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/1 1945, to 11/11 1945 and that I last saw h E.R alive on 11/11 1945.

Immediate cause of death PNEUMONIA

Due to HYPOSTASIS

Due to FRACTURE OF FEMUR (left)

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: 8/19 - 11/11 in hospital

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following. 7/14
(a) Accident, suicide, or homicide accident
(b) Date of occurrence 8/19/45 at M
(c) Where did injury occur? Balto, Md (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? HOME (Specify type of place) While at work? NO
(e) Means of injury FELL DOWN STEPS

23. Signature Charles W. Stewart JR. M.D.
Address Md. Gen. Hosp. Date signed 11/11/45

Approved: Robert A. Fortune M.D. X 11/13/45

VS 150

Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

G34127 Rieha

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G34127 Registered No.

Type or write with PERMANENT BLACK INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 634 Wicklow Rd
(c) Hospital or institution: 28

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 24 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 634 Wicklow Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary A. Rieha

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: widow.
6 (b) Name of husband or wife: late John F.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): March 14, 1862
8. AGE: Years 83 | Months 7 | Days 27 | If less than one day hr. min.
9. Birthplace: Austria (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name: Joseph F. Gruber
13. Birthplace: Austria

MOTHER
14. Maiden Name —
15. Birthplace: Austria

16 (a) Informant: Edward L. Rieha
(b) Address: 634 Wicklow Rd

17 (a) Removal (b) Date thereof 11/14/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory: Mt. Calvary
Location: Milwaukee, Wis.

18 (a) Funeral director: Harry H. Witzke
(b) Address: 4101 Edmondson Ave.

19 NOV 13 1945 (b) Huntington Williams, M.D.
(Date received by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 11 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 4 1945 to Nov 11 1945 and that I last saw her alive on Nov 11 1945.

	Duration
Immediate cause of death: Myocardial Infarction	4 hours
Due to: Thrombosis of coronary artery	4 hours
Due to: arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Vernon H. Norwood M. D.
Address 510 Woodside Road Date signed 11-12-45

-29

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634128 (1)

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

634128 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green sts.
(c) Hospital or institution: University 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 13 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 921 Lyndhurst St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John W. Elgin
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Catherine T Strasser
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct 5, 1889
8. AGE: Years 56 | Months 1 | Days 6 | If less than one day hr. min.
9. Birthplace Mo. (Town, county, and state)
10. Usual Occupation Steam fitter
11. Industry or business

FATHER
12. Name Elgin
13. Birthplace Scotland

MOTHER
14. Maiden Name
15. Birthplace Ireland

16 (a) Informant Mrs Catherine T. Elgin
(b) Address 921 Lyndhurst St
17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 11/15/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 3800 Old Frederick Rd.
18 (a) Funeral director Harry E. Wilhelm
(b) Address 4101 Edmondson
19 (a) NOV 13 1945 (b) (Date received by local registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-11 1945, at 5:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-11 1945 to 11-11 1945 and that I last saw him alive on 11-11 1945

Immediate cause of death acute pulmonary Edema

Duration

Due to

Due to

Other Conditions acute myeloid leukemia
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. E. Henry M. D.
Address Date signed

VS 150

G34129

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

G34129 Registered No.

Form 10-1 (Rev. 1-1-45) 5M. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 550 W Preston
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Ira G. Stafford

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/16/90

8. AGE: Years	Months	Days	If less than one day
55		27	hr. min.

9. Birthplace Lexville, Md.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Lincoln Stafford
13. Birthplace Sivers Broadmd

MOTHER
14. Maiden Name Julia Spicer
15. Birthplace Sivers, Broad md

16 (a) Informant Bertie Stafford
(b) Address Cambridge md

17 (a) Burial (b) Date thereof Nov 16 45
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Cemetery or crematory Cemetery
Location Sivers, Broad md

18 (a) Funeral director Sears H Gaynem
(b) Address Cambridge Md

NOV 13 1945
(Date rec'd by registrar) (By) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-13 1945, at 343 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-7 1945 to 11-13 1945, and that I last saw h(im) alive on 11-13 1945.

Immediate cause of death Congestive Heart failure - etiology undetermined — Duration 2 years Hrs long

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H H Barnfield
Address 1001 Cleveland Ave. Date signed M/D. 11/13/45

G34130

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 937

Registered No. G34130

Write the causes of death clearly and legibly. Please avoid abbreviations. Do not use ditto marks.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: University Hospital ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 759 W. Fayette Street
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Buckmaster

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/15/98

8. AGE: Years 47 | Months 5 | Days | If less than one day hr. min.

9. Birthplace Calvert Co. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) Burial (b) Date thereof 11/14/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3801 Frederick Ave

18 (a) Funeral director Harry H. Wetzler
(b) Address 4101 Edmondson Ave

19 NOV 13 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 11, 1945, at 10:35 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral hemorrhage

Due to Hypertensive Cardio-Vascular disease

Other Conditions Skull fracture (result of fall after hemorrhage.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skitarelic M.D.
Medical Examiner.
Date signed November 12, 1945.

G34131

CWK-90002

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1313

G34131 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1- 1- 0-
(e) Length of stay in Baltimore (yrs., mos., or days) 27- 10- 21

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 740 W. Redwood Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dorothy Barclay

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife John Barclay

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 7-1917

8. AGE: Years 27 | Months 10 | Days 21 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Frank Lee Robinson
13. Birthplace Maryland

MOTHER
14. Maiden Name Beatrice Bowlman
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School NOV 13 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 NOV 13 1945 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 28 1945 at 9:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 28 1944, to Oct. 28 1945 and that I last saw her alive on Oct. 28 1945.

Immediate cause of death: Pulmonary Tuberculosis — Duration: 7

Due to: Tuberculous Enteritis

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: By post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert H. Copeland Jr M.D.
Address Balto. City Hosp. Date signed 11/1/45

VS 150

3075

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34132

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G34132 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4100 N. Charles St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) ----
(e) Length of stay in Baltimore (yrs., mos., or days) About 87 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County --------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4100 N. Charles St.
(If rural give location)
(e) Citizen of foreign country? -------- (Yes or No)
If yes, name country --------

3 (a) FULL NAME Sarah A. George

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife --------
6 (c) If alive, give age --- years

7. Birth date of deceased (mo., day, yr.) --------

8. AGE: Years	Months	Days	If less than one day
About 87	---	---	-- hr. --- min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation None
11. Industry or business ------

FATHER
12. Name Andrew J. George
13. Birthplace Maryland

MOTHER
14. Maiden Name Catherine Bond
15. Birthplace Maryland

16 (a) Informant J. G. Anderson
(b) Address 4100 N. Charles St.

17 (a) Burial (b) Date thereof 11/15/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Baltimore, Md.

18 (a) Funeral director H. W. Meares and Son
(b) Address 805 N. Calvert Street

19 (a) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

NOV 13 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 12 1945, at 3:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 22 1945, to Nov. 12 1945, and that I last saw her alive on Nov. 12 1945.

	Duration
Immediate cause of death Cardiac heart failure	2 hours.
Due to Hypertensive heart disease	2 yrs. 11 mos.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Gibson Porter
Address 4822 Roland Ave Date signed 11/13/45

X

G34133 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH 131a G34133

1. PLACE OF DEATH Edgewood Nursing Home

CITY OF BALTIMORE: (No. 6000 Bellona Ave. St. Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. da. How long in U. S. If of foreign birth? yrs. mos. da.

2. FULL NAME James William Marshall

If U. S. Veteran specify WAR

(a) Residence: No. 6000 Bellona Ave. St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. Color or Race: White

5. Single, Married, Widowed, or Divorced (write the word):

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Caroline F. Marshall

6. DATE OF BIRTH (month, day, year): Feb 4 - 1862

7. AGE: Years 83 | Months 9 | Days 9 | If LESS than 1 day, hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.: Dry goods salesman

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.:

10. Date deceased last worked at this occupation (month and year):

11. Total time (years) spent in this occupation:

12. BIRTHPLACE (city or town) (State or country): Vance Mills Va

FATHER

13. NAME: Ganesville Marshall

14. BIRTHPLACE (city or town) (State or country): Va

MOTHER

15. MAIDEN NAME: Elizabeth Fray

16. BIRTHPLACE (city or town) (State or country): Va

17. INFORMANT: Elizabeth M. Rowlins

(Address) 700 Woodbourne Ave. Balto Md

18. BURIAL, CREMATION, OR REMOVAL

Place: Washington D.C. Date: 11/14 1945

19. UNDERTAKER: Joseph F. Bucks Sons

(Address) 2154 Pa Ave N.W. Wash. D.C.

20. FILED 19

NOV 14 1945

Huntington Williams

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year): Oct. 13, 1945

22. I HEREBY CERTIFY, That I attended deceased from Oct. 13, 1943 to Oct. 13, 1945

I last saw him alive on Oct 13, 1945 Death is said to have occurred on the date stated above, at 1130 P. m.

The principal cause of death and related causes of importance were as follows:

Pyonephrosis Nephrolithiasis — Date of onset: Years

Other contributory causes of importance:

Uremia Calculus Kidney Years

Was an operation performed? No Date of

For what disease or injury?

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No

(Signature) L. E. Richards M. D.

(Address) 1710 I St. N.W.

X F.W. Smith

OCCUPATION is very important. See instructions on back of Certificate.

G34134

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G34134 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2917 E. Baltimore St.
(c) Hospital or institution:
1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2917 E. Baltimore St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Rakowski

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Cunegunda

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mch. 19 1861

8. AGE: Years 84 | Months 7 | Days 23 | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Andrew Rakowski
13. Birthplace Poland

MOTHER
14. Maiden Name Unk.
15. Birthplace Poland

16 (a) Informant Mary Rakowski
(b) Address 2917 E. Baltimore St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 15/45 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Fred H. Ozarowski
(b) Address 1930 Eastern Ave.

19 NOV 14 1945 (Date received by Registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 11 1945, at 335PM

21. I certify that death occurred on the date above stated; that I attended deceased from May 26 1944 to Nov. 11 1945, and that I last saw him alive on Nov. 11 1945.

Immediate cause of death: ARTERIO SCLEROTIC CARDIO-VASCULAR DISEASE — Duration 5/26/44 To 11/11/45

Due to

Due to

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation NONE

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph F. Deenga M. D.

Address 209 S. Chester St. Date signed 11/13/45

VS 150

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34135

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170C

G34135 Registered No.

Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Md. General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 450 E Lanvale Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Melville B. Blumenberg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 28-1875

8. AGE: Years	Months	Days	If less than one day
70	4	15	hr. min.

9. Birthplace Balto Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Leopold Blumenberg
13. Birthplace Germany

MOTHER
14. Maiden Name Emilie Knorr
15. Birthplace Germany

16 (a) Informant Helen N. Piccola
(b) Address 453 Shirley ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/16/45 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Parkville Md.

18 (a) Funeral director Wm Cook Inc.
(b) Address 1217 St Paul St

19 (a) (Date rec'd by registrar) (b) Huntington Woods MD

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 13th 1945, at M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Skull fracture, Contusion of brain.

Due to

Other Conditions Fracture of both legs. Below the knee.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-11-45 at 9:15 P. M. 12/3
(b) Where did injury occur? Greenmount & 25th st
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no
(d) Means of injury pedestrian struck by auto.

23. Signature Benedict Skotarchi M.D. Medical Examiner.
Date signed 11-13-45

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34136

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered No. G34136

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution: University Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) 13 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 130 W. Mother st. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Harry W. Thomas Jr

3 (b) If veteran, name war —
3 (c) Social Security Account No. none

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: None
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 10/31/45
8. AGE: Years | Months | Days: 13 | If less than one day: hr. min.
9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Harry W. Thomas
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Caroline Lomprey
15. Birthplace Havre de Grace Md.

16 (a) Informant Caroline Lomprey
(b) Address 130 W. Mother st.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/14/45 (month) (day) (year)
(c) Cemetery or crematory Meadow Ridge
Location Baltimore Md
18 (a) Funeral director Williams & Colvin
(b) Address 1217 E. Pratt St.
19 (a) (Date rec'd by registrar) NOV (b) 14 1945
Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/13/1945, at 6:50 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/11/1945 to 11/13/1945, and that I last saw him alive on 11/13/1945.

	Duration
Immediate cause of death Ruptured cerebral aneurysm	
Due to	
Due to	
Other Conditions Septicemia and Marked Cachexia (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dabney Johnson M. D.
Address University Hosp. Date signed 11-12-45

VS 150

G34137

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 939

Registered No. G34137

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2209 Roslyn Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2209 Roslyn Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph A. Mc Caghey

3 (b) If veteran, name war

(c) Social Security Account No. 205-05-0173

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~
Male	White	Widowed

6 (b) Name of ~~husband or~~ wife Selevia McCaghey

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 26th 1865

8. AGE: Years	Months	Days	If less than one day
80	4	17	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Retired Special Representative

11. Industry or business B. & O. R.R.

FATHER
12. Name John McCaghey
13. Birthplace Ireland

MOTHER
14. Maiden Name Sarah Ann McKinley
15. Birthplace Ireland

16 (a) Informant Wm McCaghey
(b) Address 2936 Clifton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/16/45 (month) (day) (year)
(c) Cemetery ~~crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

19 (a) NOV 14 1945 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 13, 1945, at 12 45 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert A. Foster M.D.
Medical Examiner.
Date signed Nov. 13 1945

VS 151

X

G34138

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

G34138 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (~~yrs., mos., or~~ days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 607 Somerset Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Dr. C. Urban Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Willie Hinds
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May-14-1868

8. AGE: Years	Months	Days	If less than one day
77	5	28	hr. min.

9. Birthplace Baltimore Md
(town, county, and state)
10. Usual Occupation Physician
11. Industry or business Self

FATHER
12. Name Lenhaum
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs Marian McCormick
(b) Address 7 East 39th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 15/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd

18 (a) Funeral director McElligon Cook Inc
(b) Address 1411 St Paul St

19 (a) NOV 14 1945 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/12 1945, at 9:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/12 1945, to 11/12 1945, and that I last saw him alive on 11/12 1945.

Immediate cause of death	Duration
Due to Trauma to Head + neck due to fall	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 27/14
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 11/12/45 at P.M.
(c) Where did injury occur? Balt. Md.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Patients Home While at work? No.
(Specify type of place)
(e) Means of injury Fell down steps

23. Signature W. Traynor M. D.
Address Date signed 11/13/45

VS 150 Approved. Robert Lee Graham M.D. Md. Gen. Hosp. X

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly.

G34139

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G34139 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 600 S Chapel Gate Lane
(c) Hospital or institution: Lilienia Private Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 824 S Highland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Katherine Reynolds

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Wilhoure

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 5 1870

8. AGE: Years	Months	Days	If less than one day
75	0	6	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Gottfried Schuffner

13. Birthplace Germany

MOTHER 14. Maiden Name Whipsnore

15. Birthplace

16 (a) Informant Mrs Louise Dittler

(b) Address Bangor Me

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/14/45 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Balto

Location " Md

18 (a) Funeral director Thilman Coltson

(b) Address 1217 Eutaw St

19 NOV 14 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 11 1945 at 9.20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1944 to Nov 11 1945 and that I last saw her alive on Nov 11 1945

Immediate cause of death Myocardial Insufficiency — Duration 1 Week

Due to

Due to

Other Conditions: General Arterio sclerosis — Duration ?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. F. Alexander M. D.

Address 336 Fidelity Bldg Date signed 11/12/45

correct age is especially important. Physicians: please write the

VS 150

G34140

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1310

G34140 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2104 Lake Ave.
(c) Hospital or institution: 9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2104 Lake ave
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Henry T. Kidd

3 (b) If veteran, name war: no
3 (c) Social Security Account No. no.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Mary P. Kidd
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 24 - 1856

8. AGE: Years	Months	Days	If less than one day
89	3	18	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Louis A. Kidd
13. Birthplace unknown

MOTHER
14. Maiden Name Mary J. Lemick
15. Birthplace unknown

16 (a) Informant Mrs Florence J. Rice (daughter)
(b) Address 2104 Lake Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-17-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md.
18 (a) Funeral director Leonard F. Roth
(b) Address 5305 Harford Rd
19 (a) (Date received by registrar) NOV 14 1945 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 11 1945, at - M
21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1 1945 to Nov 11 1945, and that I last saw him alive on Nov 10 1945

Immediate cause of death	Duration
Malaria Regurgitation Kidneys	11 d.
Due to Arteriosclerosis	11 d.
Due to Chronic Interstitial Nephritis	11 d.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature T F A Stevens M.D.
M. D.
Address 2818 Harford Rd Date signed 11-13-45

VS 150

X

634141

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. 634141

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 900 Argonne Drive
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 7 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 900 Argonne Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARIE E. ANGIER

3 (b) If veteran, name war

3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife John C. Angier
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 12, 1908

8. AGE: Years	Months	Days	If less than one day
37	10	0	hr. min.

9. Birthplace Pa. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Wm. H. Sheriff
13. Birthplace Pa.

MOTHER
14. Maiden Name Eva Probst
15. Birthplace Pa.

16 (a) Informant Mr. John C. Angier
(b) Address 900 Argonne Drive

17 (a) burial (Burial, cremation, or removal) (b) Date thereof Nov. 15, 1945 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto., Md.

18 (a) Funeral director Lansdale Funeral Home
(b) Address 7401 Belair Road

19 NOV 14 1945 (Date rec'd by registrar) (c) Lexington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH November 12, 1945, at 12:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/7 1945 to 11/12 1945, and that I last saw her alive on 11/12 1945

Immediate cause of death Pulmonary Embolism — Duration 1 hr.
Due to Thrombotic Pneumonia, Atypical (Virus) — Duration Since Oct 7
Due to — Duration
Other Conditions — Duration

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 2020 Clarey Date signed 11/13/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

VS 150

G34142

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G34142 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly. The return of information should be carefully supplied. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Bon Secour Hospital
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 510 E. Randall St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Sophia Geary

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Walter R. Geary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 16, 1885

8. AGE: Years 59 | Months 10 | Days 26 27 | If less than one day hr. min.

9. Birthplace Balto. Co., Md. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name John Rosengarn
13. Birthplace Unknown

MOTHER
14. Maiden Name Caroline Gegner
15. Birthplace Unknown

16 (a) Informant Mr. Walter R. Geary
(b) Address 510 E. Randall St.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof Nov. 16, 1945 (month) (day) (year)
(c) Cemetery or crematory Zion Lutheran
Location Stemmers Run, Md.

18 (a) Funeral director Townshend Funeral Home
(b) Address 7401 Belair Road

19 (a) (Date rec'd by registrar) (b) Washington Wilkerson M.D. Registrar

NOV 14 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/12 1945, 3:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/7 1945 to 11/12 1945 and that I last saw h[illegible] alive on 11/12 1945.

Immediate cause of death Pulmonary Embolus — Duration

Due to Chronic Myocarditis

Due to

Other Conditions Hypertension Diabetes Mellitus
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature F. L. Shirkey Jr. M. D.
Address Bon Secours Hosp. Date signed 11/14/1945

935

G34143

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G34143 Registered No.

Type or print plainly with pen. Do not write over printed words. Give all the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 14

(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1527 Mc Culloh Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William M. Murray

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-14-0155

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-1-1877

8. AGE: Years	Months	Days	If less than one day
68	5	12	hr. min.

9. Birthplace Calvert County, Md.
(Town, county, and state)

10. Usual Occupation Butler

11. Industry or business

FATHER
12. Name Thomas J. Murray
13. Birthplace Maryland

MOTHER
14. Maiden Name Maria C. Johnson
15. Birthplace Maryland

16 (a) Informant John S. Murray - Brother
(b) Address 1027 Edmondson Ave.

17 (a) Burial (b) Date thereof 11-16-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Island Creek
Location Calvert Co. Md.

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

19 (a) (b)
(Date received by registrar) (Registrar)

VS Form 10 NOV 14 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH November 13, 1945, at 8:47 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Preston M.D.
Medical Examiner.
Date signed Nov. 13 1945

X

G34144

CWK-96792

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

G34144

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 418 N. Exeter Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert Hamilton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Myrtle Hamilton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 27th, 1909

8. AGE: Years	Months	Days	If less than one day
36	4	14	hr. min.

9. Birthplace Kentucky
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Albert Hamilton
13. Birthplace ?

MOTHER
14. Maiden Name Elistey Conley
15. Birthplace ?

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof Nov 16, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Fullerton Cemetery
Location Fullerton Graveyard Co. Md.

18 (a) Funeral director Clarence W. Cartlidge Son
(b) Address 924 E. Eager St.

19 (a) (b)
(Date received by registrar)

NOV 14 1945

Huntington Williams, M.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 11 1945, at 4:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 20 1945, to Nov. 11 1945, and that I last saw h. im alive on Nov. 11 1945

Immediate cause of death	Duration
Pulmonary Tuberculosis	?
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert B. Copeland Jr. M. D.
Address Balt. City Hosp. Date signed 11/13/45

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly. The items of information should be carefully supplied.

G34145

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13a

G34145 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 611 Collett st
(c) Hospital or institution: 15

(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 611 Collett st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Moss.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 9-11-1901

8. AGE: Years 44 | Months 2 | Days 1 | If less than one day ... hr. ... min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name unknown
13. Birthplace

MOTHER 14. Maiden Name unknown
15. Birthplace

16 (a) Informant Irine Harris
(b) Address 611 Collett st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 14 45 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore Md

18 (a) Funeral director William A Jackson
(b) Address 916 Penna ave

19 (a) Filed NOV 14 1945 Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 12 1945, at 9 a.m.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-31-1945, to 11-12 1945, and that I last saw h alive on 11-11 1945.

Immediate cause of death Chronic Cardio Vascular Renal Disease — Duration 1 yr

Due to —

Due to —

Other Conditions —
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury —

23. Signature [illegible] M.D.
Address 600 N Arlington Ave Date signed 11/13/45

G34146

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 D

G34146 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 617 S. Streeper St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 617 S. Streeper St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Balcer or Bolcer

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex M

5. Color or race W.

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years 65 | Months | Days | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Acme Box Co

FATHER 12. Name

13. Birthplace Poland

MOTHER 14. Maiden Name

15. Birthplace Poland

16 (a) Informant Frances Plum

(b) Address 617 S. Streeper St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-15-45 (month) (day) (year)

(c) Cemetery or crematory St. Stanislaus

Location Balto. City

18 (a) Funeral director Wm. S. Fialkowski

(b) Address 2007 Eastern ave

19 (a) (Date rec'd by registrar) (b) Huntington Woodstock, Md.

NOV 14 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-12-45 19 at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1 1945 to Nov 12 1945, and that I last saw h[illegible] alive on Nov 12 1945

Immediate cause of death Coronary Thrombosis — Duration 11/10/45

Due to Chr. Myocarditis — Duration Jul 1945

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Williams J Rykaweck

Address 801 N Kenwood Ave Date signed 12-13-45 D.

X

vs 11

Item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34147

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G34147

CERTIFICATE OF DEATH 52B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
U.S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 165 days
(e) Length of stay in Baltimore (yrs., mos., or days): 165 days

2. USUAL RESIDENCE OF DECEASED:
(a) State: DC (b) County:
(c) City or town: Washington
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 722 Tewkesbury Place, NW
(If rural give location)
(e) Citizen of foreign country? --- (Yes or No)
If yes, name country:

3 (a) FULL NAME: De Lury, Robert Emmett

3 (b) If veteran, name war: I
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife: Allie DeLury
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.): May 23, 1875

8. AGE: Years	Months	Days	If less than one day
70	5	19 20	hr. min.

9. Birthplace: Ontario, Canada
(Town, county, and state)
10. Usual Occupation: none
11. Industry or business:

FATHER
12. Name: Daniel DeLury
13. Birthplace: Ireland

MOTHER
14. Maiden Name: ?
15. Birthplace: ?

16 (a) Informant: Records
(b) Address: US Marine Hospital, Balto, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 15/45 (month) (day) (year)
(c) Cemetery or crematory: Toronto
Location: Toronto, Canada
18 (a) Funeral director: John O'Neill Sons Funeral Home
(b) Address: 196 Bertar Place
19 (a) (b) NOV 14 1945 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

P

20. DATE OF DEATH: Nov. 12 1945, at 4:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 30 1945, to Nov. 12 1945, and that I last saw him alive on Nov. 12 1945.

Immediate cause of death: Carcinoma of urinary bladder with bilateral ureteral ob-
Due to: struction and cystitis.
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: As above

Duration: Unknown

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: John K. McBane
John K. Mc Bane, PA Surgeon M. D.
Address: US Marine Hospital Date signed 11/13/45
Balto, Md.

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34148

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G34148

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4328 Falls Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 40 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4328 Falls Road
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Bertha Virginia Fisher

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Garner M. Fisher
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 8-1888

8. AGE: Years	Months	Days	If less than one day
57	3	4	hr. min.

9. Birthplace Jefferson Co. W. Virginia
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name John L. Silk
13. Birthplace W. Virginia

MOTHER
14. Maiden Name Mary E. J. Groves
15. Birthplace W. Virginia

16 (a) Informant Garner M. Fisher Jr.
(b) Address 4328 Falls Road

17 (a) Burial (b) Date thereof Nov. 15-1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore Co Md.

18 (a) Funeral director Burger Funeral Home
(b) Address 3631 Falls Road

19 (a) NOV 14 1945 (b) Huntington Williamsport, MD
(Date rec'd by registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 12- 1945, at 10:30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1st 1944 to Nov 11th 1945.
and that I last saw h[illegible] alive on Nov 11th 1945.

Immediate cause of death	Duration
Coronary occlusion? Senility ?	
Due to Probably arteriosclerotic	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. A. Silliard
Address 3614 Falls Rd. Date signed 11/12/45 M. D.

correct age is especially important. Physicians: please write the

G34149

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V63a G34149 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3728 Greenmount Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) 10 months

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri County Platt County
(c) City or town ~~Baltimore~~ Parkville
(If outside city or town limits, write RURAL and give town)
(d) Street No. ~~3728 Greenmount Ave.~~
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Eliza E. Vest

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Thomas Coomes Vest
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 22nd 1866

8. AGE: Years 79 | Months 3 | Days 21 | If less than one day hr. min.

9. Birthplace Kansas (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Thomas Jefferson Herndon
13. Birthplace Kentucky

MOTHER
14. Maiden Name Louise Anderson
15. Birthplace Kentucky

16 (a) Informant Mrs. Beulah Hamilton
(b) Address Parkville Mo.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 14-1945 (month) (day) (year)
(c) Cemetery or crematory Parkville
Location Parkville, Missouri

18 (a) Funeral director Burger Funeral Home
(b) Address 3021 Falls Road

19 (a) (Date rec'd by registrar) NOV 14 1945 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 13th 1945, at 8:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from February 1945 to Nov. 13th 1945 and that I last saw h.. alive on Nov. 13 1945.

Immediate cause of death: Cerebral Hemorrhage — Duration 9 mo.
Due to: Arteriosclerosis — 15 yrs.
Due to: Senility — 10 yrs.
Other Conditions: None

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations: None
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide None
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. S. Clafford M.D.
Address 6210 York Road Date signed Nov 13 1945

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

G34150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1131a

G34150 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2301 N. Longwood St.
(c) Hospital or institution: 15th
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2301 N. Longwood St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME AUSTIN HOWARD GEISELMAN, JR.

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 215-10-1575

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Divorced

6 (b) Name of husband or wife Laura Mae Geiselman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 17, 1899

8. AGE: Years 46 | Months 3 | Days 25 | If less than one day hr. min.

9. Birthplace Westminster, Md. (Town, county, and state)

10. Usual Occupation Vice President

11. Industry or business Fidelity & Deposit Co.

FATHER
12. Name Austin H. Geiselman, Sr.
13. Birthplace Pa.

MOTHER
14. Maiden Name Irene Everhart
15. Birthplace Manchester, Md.

16 (a) Informant Mrs. Laura Mae Geiselman
(b) Address 2301 N. Longwood St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/15/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 14 1945 (b) Registrar's signature Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 12, 1945, at 9.45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 7 1945 to Nov 12 1945 and that I last saw h[illegible] alive on Nov 11 1945.

Immediate cause of death: Coronary Thrombosis ✓ — Duration

Due to: Myocardial Degeneration ✓

Due to: Due to Atherosclerosis ✓

Other Conditions ✓

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: ✓

of autopsy: none

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ✓
(b) Date of occurrence ✓ at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John A. Gehrke M.D.

Address 1219 Eyster Bldg. Date signed Nov 14 1945.

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34151

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 F

Registered No. G34151

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 9 S. Fremont Ave
(c) Hospital or institution: 4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 9 S. Fremont Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Lett

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Thomas W.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/19/1894

8. AGE: Years	Months	Days	If less than one day
51	7	23	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Scott Halverton
13. Birthplace Va.

MOTHER
14. Maiden Name Katie ?
15. Birthplace Va.

16 (a) Informant Mr. Thomas W. Lett
(b) Address 9 S. Fremont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/15/45 (month) (day) (year)
(c) Cemetery or crematory St. Peter's Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 1 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 12th 1945 at M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Carcinoma of Liver

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mulleis M.D.
Medical Examiner.
Date signed 11-13-45

G34152

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G34152
Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd Street
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days.
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3901 Jennifer Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HATTIE G. BRAMBLE

3 (b) If veteran, name war: --

3 (c) Social Security Account No.: --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Wm. Forest Bramble
6 (c) If alive, give age 7 years

7. Birth date of deceased (mo., day, yr.) April 24, 1873

8. AGE: Years	Months	Days	If less than one day
72 71	6	20 19	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William E. Bramble (D)
13. Birthplace Maryland

MOTHER
14. Maiden Name Caroline A. Davis (D)
15. Birthplace Maryland

16 (a) Informant Husband
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/15/45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.
18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.
19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 13 1945 at 9 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/12/1945, to 11/13/1945 and that I last saw her alive on 11/12/1945.

Immediate cause of death	Duration
Arteriosclerotic heart disease	
Due to Arteriosclerosis, generalized	
Due to Diabetes mellitus	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 0
Major findings of operation: 0
of autopsy: Cerebellar ataxia

PHYSICIAN
Underline the cause to which death should be assigned.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. L. Sanders M. D.
Address Union Memorial Hosp. Date signed 11/13/45

VS 150 NOV 14 1945 Hunterstown Williams, M.D.

G34153

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G34153

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 908 N. Fayette St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 908 N. Fayette St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice McAllister

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F.

5. Color or race C.

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife James L. McAllister

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 21, 1923

8. AGE: Years 12 | Months 0 | Days 21 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Daniels
13. Birthplace North Carolina

MOTHER
14. Maiden Name Jennie Terrell
15. Birthplace

16 (a) Informant James L. McAllister
(b) Address 908 N. Fayette St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-16-45 (month) (day) (year)
(c) Cemetery or crematory Ant. Auburn
Location West Port, Maryland

18 (a) Funeral director Charles L. Law
(b) Address 802 Madison Ave.

19 (a) Nov 16 1945 (Authorized by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11.12.1945 at 12:47 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 2 1945 to Nov 12 1945 and that I last saw h. alive on Nov 12 1945.

Immediate cause of death Lobar pneumonia — Duration 10 days

Due to

Due to (open)

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. D. Carr M. D.

Address 515 Worlen Pl. Date signed 11.14.45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Nov 1

Huntington Williams, M.D.

Va 130

G34154

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G34154

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Park Ave + Whitelock St
(c) Hospital or institution: 600 Whitelock St. 1351
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 12 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. Lafayette Apts (If rural give location)
(e) Citizen of foreign country? Reforest (Yes or No)
If yes, name country

3 (a) FULL NAME MAURICE H. GARLAND

3 (b) If veteran, name war —

3 (c) Social Security Account No. 093-01-7356

4. Sex MALE | 5. Color or race WHITE | 6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife HENRIETTA

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1891

8. AGE: Years 54 | Months | Days | If less than one day hr. min.

9. Birthplace JERSEY CITY N.J (Town, county, and state)

10. Usual Occupation SALESMAN

11. Industry or business

FATHER
12. Name SAMUEL
13. Birthplace RUSSIA

MOTHER
14. Maiden Name CATHERINE
15. Birthplace RUSSIA

16 (a) Informant WIFE
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-14-45 (month) (day) (year)
(c) Cemetery or crematory Southern Ave
Location Southern Ave

18 (a) Funeral director JACK LEWIS INC
(b) Address 1439 E. Balto. St

NOV 14 1945 (Date rec'd by registrar) (b) Hamilton Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-13- 1945 at 4 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/12 1945 to 11/13 1945, and that I last saw h[illegible] alive on 11/12 1945.

Immediate cause of death Coronary Thrombosis — Duration 4 hrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John H Gordon M.D.
Address 3400 E Balto St Date signed 11/13/45

X

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

34155

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1222

G34155 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 0
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2306 N. Fayette St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Mary Francis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	Widowed

6 (b) Name of husband or wife Joseph B.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 29, 189[illegible]

8. AGE: Years	Months	Days	If less than one day
53	2	15	hr. min.

9. Birthplace Balt.
(Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name John J. Reardon
13. Birthplace Md.

MOTHER
14. Maiden Name Annie Earley
15. Birthplace Ireland

16 (a) Informant Mrs. Agnes Rearden
(b) Address 2306 N. Fayette St.

17 (a) Burial (b) Date thereof Nov. 16, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balt.

18 (a) Funeral director George A. Earley
(b) Address Sutton Ave Fayette St

NOV 14 1945 Huntington Williams MD
(Date received) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/13/19[illegible], at M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/5/1945 to 11/13/1945 and that I last saw her alive on 11/13/1945

Immediate cause of death Acute Cardiac Dilitation — Duration 24 hrs.
Due to Post. Op. A.P.P. — Resect of Omentum.
Due to Paralytic Ileus.
Other Conditions Obesity
(Include pregnancy within 3 months of death)
Date of operation 11/7/45
Major findings of operation: Hypertrophy of Omentum Chr. APP
of autopsy: X

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John Dorton Jr. M.D.
Address Bon Secours Hosp. Date signed 11/13/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X

G34156

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

G34156 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3422 Chestnut Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 D
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3422 Chestnut Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie E. Hood.

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married.

6 (b) Name of husband or wife Milbert W. Hood.
6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) March 19, 1879

8. AGE: Years	Months	Days	If less than one day
66	7	25	..... hr. ..... min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John M. Martin.
13. Birthplace Maryland.

MOTHER
14. Maiden Name Julia Jones
15. Birthplace Maryland.

16 (a) Informant Milbert W. Hood.
(b) Address 3422 Chestnut Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 15/45 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Woodlawn.
Location
18 (a) Funeral director Chenowith & Donovan
(b) Address 3615-17 Chestnut Ave.
19 (a) (Date received by Registrar) (b) Registrar

NOV 14 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 13, 1945, at 5:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 16 1945 to Nov 13 1945 and that I last saw h— alive on Nov 12 1945.

Immediate cause of death	Duration
Myocardial degeneration	
Due to	
Due to	
Other Conditions Arteriosclerosis Hypertension	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operations: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury —

23. Signature Huntington Williams, M.D.
Address 0429 Chestnut St. Date signed 11/14/45

Huntington Williams, M.D.

Wm. H. Smith X

G34157 **HEALTH DEPARTMENT—CITY OF BALTIMORE** G34157

CERTIFICATE OF DEATH

✓94a

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1235 N. Patterson Park ave St., 4 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S. If of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME Stephen Frederick Albrecht

If U. S. Veteran specify WAR .....

(a) Residence: No. 1235 N. Patterson Park ave St., ... Ward. .....

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Lilly May Albrecht

6. DATE OF BIRTH (month, day, year) ~~August 23~~ July 23 1884

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
61 61	3	20 21	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Clerk

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Maryland Drydock

10. Date deceased last worked at this occupation (month and year) 1943

11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

FATHER

13. NAME Frederick Albrecht.

14. BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

MOTHER

15. MAIDEN NAME Caroline Barbara Herbrich.

16. BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

17. INFORMANT Mrs. Lilly May Albrecht

(Address) 1235 N. Patterson Park ave

18. BURIAL, CREMATION, OR REMOVAL

Place Holy Redeemer Date Nov 17th 1945

19. UNDERTAKER Leo L. Leavoh

(Address) 1761-63 N. Patterson Park Ave.

20. FILED ..... 19... Huntington Williams

NOV 14 1945

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) 11/13, 1945

22. I HEREBY CERTIFY, That I attended deceased from November 2, 1945 to November 13, 1945

I last saw him alive on 11/7, 1945. Death is said to have occurred on the date stated above, at 1125 a.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Coronary Occlusion	11/13/45
due to Coronary Sclerosis	1 year
Other contributory causes of importance: Obesity	Life

Was an operation performed? No Date of .....

For what disease or injury? .....

Name of operation .....

What test confirmed diagnosis? ..... Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ....., 19...

Where did injury occur? .....

(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place .....

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased?

If so, specify .....

(Signed) W. Grafton Hersperger M. D.

(Address) 214 Medical Arts Building

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

X

G34158

BALTIMORE CITY HEALTH DEPARTMENT 83a

CERTIFICATE OF DEATH

G34158 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 123 N. Carey St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 123 N. Carey St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** George Washington Thompson
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widower

6 (b) Name of husband or wife Jessie Thompson (c) If alive, give age 78 years

7. Birth date of deceased (mo., day, yr.) Apr 3 1866

8. AGE: Years 78 | Months 7 | Days 12 | If less than one day ..... hr. ..... min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Pattern Maker

11. Industry or business B & O. R.R.

FATHER 12. Name John A.
13. Birthplace Md.

MOTHER 14. Maiden Name Mary School
15. Birthplace

16 (a) Informant John A. Thompson
(b) Address 123 N. Carey St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 16 '45 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto. Md.

18 (a) Funeral director Thos. J. Kenny Inc.
(b) Address 1601 Holbrook St.

19 (a) (Date rec'd by registrar) (b) Huntington Will Brokenborough Md

NOV 14 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 14 1945, at 1:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1945 to Nov. 14 1945 and that I last saw him alive on 11/13 1945

Immediate cause of death — Duration

Cerebral Hemorrhage — July 1-45

Due to Arterial Sclerosis

Due to Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chas. Adams M. D.
Address 2145 W Balto Date signed 11/14/45

X

G34159

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1467

Registered No. G34159

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 338 S. Calhoun St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 338 S. Calhoun St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Annie E. Kurtz

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Clarence J.

6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) Feb 28 1893

8. AGE: Years 52 | Months 8 | Days 14 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business House Wife

FATHER
12. Name James Hines
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Mary Kelly
15. Birthplace Baltimore Md

16 (a) Informant Annie M. Semmont
(b) Address 1400 Ramsay St

17 (a) Burial (b) Date thereof Nov 15 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location City

18 (a) Funeral director Pratt C. & B. M. Walter
(b) Address Pratt & Fulton Sts

19 (a) NOV 14 1945 (b) Huntington West Virginia
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 12 1945, at 7 30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1945, to Nov 12 1945, and that I last saw h[illegible] alive on Nov 12 1945.

Immediate cause of death Cancer of Rectum — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert Hermsen M. D.
Address 1934 W Lanvale Ave Date signed

X

G34160

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G34160 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2725 Presbury St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 hr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2725 Presbury St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nellie Rodenhiser

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Divorced

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 17 1873

8. AGE: Years	Months	Days	If less than one day
72	8	26	hr. min.

9. Birthplace Williamsport Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Agnes P. Gist
(b) Address 2725 Presbury St

17 (a) Burial (b) Date thereof Nov 16-1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location City

18 (a) Funeral director C. P. M. Walters
(b) Address Pratt & Stricker Sts

19 (a) (Date rec'd by registrar) (b) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH November 12 1945 at 4 55 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 13 1945, to Nov. 12 1945 and that I last saw her alive on Nov. 10, 1945.

Immediate cause of death	Duration
Carnary occlusion - about	1 hr.
Due to Hypertension & arterio	
Due to sclerosis	?
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Agnes Stricker

Address 2220 Garrison Blvd Date signed M. D. 11/13/4

X

G34161

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30 c G34161

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Harford Road and Herring Run
(c) Hospital or institution:
Sydenham Hospital ID
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Unknown

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 929 N. Eden. St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Harry SunKett JR

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife Feb 28, 1922

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) (Jan. 26, 1919)

8. AGE: Years	Months	Days	If less than one day
23 (22)	08	(16)18	hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Harry SunKett, SR
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary Lewis
15. Birthplace North Caroling

16 (a) Informant hospital records
(b) Address Sydenham Hospital

17 (a) Burial (b) Date thereof Nov. 15-1945
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Calvary
Location B. A. Co. Md.

18 (a) Funeral director Belmont Mamie Dr Dwight
(b) Address 721 Pennsylvania Ave

19 (a) 11 1945 (b) Washington Williams Undertaker
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 11 1945 at 7 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-10- 1945 to 11-11 1945 and that I last saw him alive on 11-11 1945

Immediate cause of death	Duration
Meningitis	
Due to unknown etiology	
Due to	
Other Conditions Treated syphilis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Margaret M. D. Smith M. D.
Address Sydenham Hosp. Date signed 11-11-45

X

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34162

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G34162 Registered No. 1570

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa (b) County
(c) City or town Mt Pleasant (If outside city or town limits, write RURAL and give town)
(d) Street No. 217 S. Desmond (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Paul Fasano

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-26-45

8. AGE: Years | Months 2 | Days 19 | If less than one day hr. min.
2 weeks 19

9. Birthplace Pa (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Paul Fasano
13. Birthplace

MOTHER 14. Maiden Name Virginia Kundrat
15. Birthplace Pa

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 16/45 (month) (day) (year)

(c) Cemetery or crematory
Location Mt Pleasant Pa

18 (a) Funeral director John O. Mitchell & Son
(b) Address 1900 Eutaw Place

19 (a) Date received Nov 17 1945 (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 14 1945 at 11 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 13 1945 to Nov 14 1945 and that I last saw h alive on Nov 14 1945.

Immediate cause of death Shock due to Duration
Operative Hemorrhage.

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation 11/13/45

Major findings of operation: Shock due to Operative Hemorrhage

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence Nov. 14, 1945 at M
(c) Where did injury occur? Baltimore Md
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Hospital While at work? No
(Specify type of place)
(e) Means of injury Operation operating Table

23. Signature Ruth V. Chambers
Address Ruth Hopkins Hosp Date signed 11/14/45
Balto. Md.

VS 150

Append: Robert the Trustee vs. B

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34163
482609

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 135a

Registered No. G34163

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1522 Brentwood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dorothy Green.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Black

6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-11-28

8. AGE: Years 17 | Months 8 | Days 3 | If less than one day ..... hr. ..... min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Green
13. Birthplace md

MOTHER
14. Maiden Name Rose Ridgely
15. Birthplace md.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 11-17-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location Baltimore

18 (a) Funeral director Chas H. Alexander
(b) Address 1200 McCulloh St

19 (a) (b)
(Date received by registrar)

NOV 15 1945

Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov-14 1945 at 4.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct-25 1945 to Nov 14 1945, and that I last saw her alive on Nov-14 1945

Immediate cause of death: Respiratory failure — Duration:
Due to: Peritonitis
Due to: Urachal abscess
Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: Urachal abscess
of autopsy: Peritonitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence 8-14-45 at 4.30 PM
(c) Where did injury occur? Balto (City or town) Md (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. Kastrup M. D.
Address Hopkins Hospital Date signed 11-19-45

correct age is especially important. Physicians: please write the ... every item of information should be carefully supplied. The ... PRINTING INK.

G34164 | BALTIMORE CITY HEALTH DEPARTMENT | G34164

CERTIFICATE OF DEATH 121

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 560 Radnor
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Rainaldi

3 (b) If veteran, name war —
3 (c) Social Security Account No. none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: widowed.

6 (b) Name of husband or wife: Samuel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 10. 1886

8. AGE: Years 58 | Months 11 | Days 3 | If less than one day: hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Joseph Manella
13. Birthplace Italy

MOTHER
14. Maiden Name unknown
15. Birthplace Italy

16 (a) Informant John Rainaldi
(b) Address Italy

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 17-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director William Cook Inc
(b) Address 217 St Paul Street

19 (a) Filed (by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 13 1945 at 9.05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 28 1945 to Nov. 13 1945 and that I last saw her alive on Nov. 13 1945

Immediate cause of death: Intestinal obstruction — Duration 48 hrs.
Due to: Appendiceal Abscess — 2 wks.
Due to: Acute Gangrenous Appendicitis — 3 wks.
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Intestinal Obstruction

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John S. Martin, M.D.
Address University Hosp Date signed 11/14/45

VS 150

G34165

HEP #88708

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G34165

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 - 4 - 17
(e) Length of stay in Baltimore (yrs., mos., or days) 72 - 7 - 4

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1803 Linden Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward V. Mercer or Edward Mercier

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Mamie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 9, 1873

8. AGE: Years	Months	Days	If less than one day
72	7	4	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation None.

11. Industry or business

FATHER
12. Name William Edward Mercer
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Emily Ruth Mercer
15. Birthplace Balto., Md.

16 (a) Informant Balto. City Hospitals Records
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof Nov. 15. 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Frederick Road

18 (a) Funeral director Wetzian Goods Inc
(b) Address 1217 E. Fayette Street

19 (a) NOV 15 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 13, 1945 at 6:25a M

21. I certify that death occurred on the date above stated; that I attended deceased from June 26, 1945 to Nov. 13, 1945, and that I last saw him alive on Nov. 13, 1945

Immediate cause of death	Duration
Cerebral hemorrhage	
Due to arteriosclerotic heart disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: none

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature T. P. Jernigan M. D.
Address Baltimore City Hosp. Date signed 11-14-45

X

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34166

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G34166

Please write plainly with pen or pencil. Do not use ink. Make entries on all lines. If none, write none. If unknown, write unknown. Be sure to answer all questions. Cause of death must be certified by a physician. Sign and return this certificate to the undertaker.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2½ hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 120 Monroe.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sam Freeman

3 (b) If veteran, name war	3 (c) Social Security Account No.
–	–

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	–

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School NOV 14 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) NOV 13 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-1- 1945, at 2 A M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardio-vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Malpas M.D.
Medical Examiner.
Date signed 11-1-45

3078

X

G34167

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G34167

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Johns Hopkins Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 D
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1626 E. Biddle St.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Pete Cannon

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1910

8. AGE: Years	Months	Days	If less than one day
35			..... hr. ..... min.

9. Birthplace.....
(Town, county, and state)

10. Usual Occupation.....

11. Industry or business

FATHER
12. Name.....
13. Birthplace

MOTHER
14. Maiden Name.....
15. Birthplace

16 (a) Informant.....
(b) Address

17 (a).....(b) Date thereof.....
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory.....
Location University Medical School NOV 14 1945

18 (a) Funeral director Commissioner of Health
(b) Address.....

19 NOV 15 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 6th 1945 at 5 40 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis
as function of Myocarditis

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury.....at.....M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?.....While at work?.....
(d) Means of injury.....

23. Signature Robert L. Proctor M.D.
Medical Examiner.
Date signed 11-7-45

VS 151

F 3079

X

G34168

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G34168 Registered No.

Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp. 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) D. 04
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4 W. 20th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Fox

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1890

8. AGE: Years	Months	Days	If less than one day
55			hr. min.

9. Birthplace
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name

13. Birthplace

MOTHER
14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location University Medical School NOV 14 1945

18 (a) Funeral director Commissioner of Health

(b) Address

19 NOV 15 1945 (Date rec'd by registrar) (Huntington Williams M.D.)

VS 151

3080

MEDICAL CERTIFICATION

55

20. DATE OF DEATH Nov. 7 1945, at 10 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cardiac hypertrophy + dilatation

Due to Arteriosclerotic Cardiovascular renal disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Robert Lee Sutton M.D.
Medical Examiner.

Date signed Nov 7 1945

G34169

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G34169
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St.
(c) Hospital or institution:
Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Balto. Essex
(If outside city or town limits, write RURAL and give town)
(d) Street No. Route 16 Box 66-21
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Anthony Neuman Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
		1 day.	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Anthony Neuman Sr.
13. Birthplace Hazelton, Pa.

MOTHER
14. Maiden Name Margaret Prokop
15. Birthplace St. Johns, Pa.

16 (a) Informant Mother Margaret Neuman
(b) Address R Route 16 Box 66 #21

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location University Medical School NOV 14 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 NOV 15 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 3, 1945, at 4 30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19
and that I last saw h alive on 19

Immediate cause of death	Duration
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. D.
Address Date signed

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 8

3081

G34170

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G34170

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1240 CLEAVELAND ST
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE V
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1240 CLEAVELAND ST
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** WALTER KEILHOLTZ

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: MALE | 5. Color or race: WHITE | 6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife EMMA KEILHOLTZ

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) FEB - 29 1872

8. AGE: Years 73 | Months 8 | Days 16 | If less than one day ..... hr. ..... min.

9. Birthplace BALTIMORE MD
(Town, county, and state)

10. Usual Occupation MECHINEST.

11. Industry or business —

FATHER
12. Name JAMES KEILHOLTZ
13. Birthplace MARYLAND

MOTHER
14. Maiden Name SUSAN WIGLEY
15. Birthplace VIRGINIA

16 (a) Informant WALTER L. KEILHOLTZ
(b) Address 3020 EDMONDSON. AV

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof NOV 17-45 (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK.
Location BALTO MD

18 (a) Funeral director Bernard C Hahn
(b) Address 121 E West St

19 (a) ..... (Date rec'd by registrar) (b) ..... Registrar

VS 190 NOV 15 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH NOV 14 1945 at 2.45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/11 1945 to 11/14 1945 and that I last saw h alive on 11/18 1945

Immediate cause of death	Duration
Congestion	4 days
Pneumonia	
Due to	
Due to	
Other Conditions Pulmonary Edema	1 day

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature]

Address 721 Medford St Date signed 11/14/45

correct age is especially important. Physicians; please write the causes of death clearly and legibly.

G34171 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 34171

CERTIFICATE OF DEATH

109a

1. PLACE OF DEATH Volunteers of Amer. Hospt. Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 41 E. W. Pennsylvania) St., Ward)

Length of residence in city or town where death occurred yrs. mos. 9 ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME ABRAHAM DURHAM, JR. If U. S. Veteran specify WAR

(a) Residence: No. 109 W. Lee St. St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
M	W	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, year) NOV 5 1945

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
		9	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, lawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Balto MD

FATHER

13. NAME Abraham Durham

14. BIRTHPLACE (city or town) (State or country) Bell County Ky.

MOTHER

15. MAIDEN NAME Margie Baker

16. BIRTHPLACE (city or town) (State or country) Hardin County Ky.

17. INFORMANT Margie Durham
(Address) 109 W. Lee St.

18. BURIAL, CREMATION, OR REMOVAL
Place University Medical School Date NOV 14 1945

19. UNDERTAKER Commissioner of Health
(Address)

20. FILED NOV 15 1945 Thurlington Williams M.D.
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Nov. 13, 1945

22. I HEREBY CERTIFY, That I attended deceased from Nov. 5, 1945, to Nov. 13, 1945

I last saw him alive on Nov. 13, 1945. Death is said to have occurred on the date stated above, at 8:00 p.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Virus Pneumonia	11/11/45

Other contributory causes of importance:

Was an operation performed? Date of

For what disease or injury?

Name of operation

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? Date of injury, 19

Where did injury occur?
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) Leonard Capps M. D.
(Address) Volunteers Hospital 11/14/45

VS 5

F 3083 X

G34172

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 D

G34172
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-0-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 618 N. Wiston ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Daniel J. Graham

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	—

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1865

8. AGE: Years	Months	Days	If less than one day
60			hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name August Graham.
13. Birthplace Germany.

MOTHER
14. Maiden Name Caroline Bastart.
15. Birthplace Germany.

16 (a) Informant Hosp. Records.
(b) Address

17 (a) Buried (b) Date thereof 11/15/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location Oldornell St

18 (a) Funeral director Lilly & Zahn
(b) Address 413 N. Broadway

19 (a) NOV 15 1945 (b)
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-6-1945 at 10 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mullen M.D.
Medical Examiner.
Date signed 11-6-45

Huntington Williams, MD

G34173

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93c

G34173 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green Sts
(c) Hospital or institution: University Hospt.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County a a
(c) City or town Jessups.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Fort Meade Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Peregine White Brown

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Charlotte M Brown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 21, 1924

8. AGE: Years	Months	Days	If less than one day
20	3	26	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Merchant
11. Industry or business General store

FATHER
12. Name Geo E Brown
13. Birthplace Mass

MOTHER
14. Maiden Name Elizabeth Clark
15. Birthplace Md.

16 (a) Informant Geo E Brown
(b) Address Jessups Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-16-45 (month) (day) (year)
(c) Cemetery or crematory Warfield
Location Fort Meade Md.

18 (a) Funeral director DeWitt Donaldson
(b) Address Laurel Md

19 (a) NOV 15 1945 (Date filed by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/14 1945, at 1 30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/12 1945 to 11/14 1945, and that I last saw h[illegible] alive on 11/14 1945.

Immediate cause of death	Duration
Cardiac failure	
Due to Acute pneumonia	
cardiovascular disease, advanced	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Alan H. Homewood M. D.
Address Univ Hospital Date signed 11/15

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

VS 150

Huntington Williams, M.D.

G34174 BALTIMORE CITY HEALTH DEPARTMENT G34174

CERTIFICATE OF DEATH 131a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1512 E. Madison St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1512 E. Madison St
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Greenbury Spencer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 11 1869

8. AGE: Years 75 | Months 11 | Days 2 | If less than one day ... hr. ... min.

9. Birthplace A. A. Co Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name James Spencer
13. Birthplace A. A. Co. Md.

MOTHER
14. Maiden Name Harriet
15. Birthplace A. A. Co. Md.

16 (a) Informant Rubin Spencer
(b) Address 1072 E. Madison St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 18 1945 (month) (day) (year)

(c) Cemetery or crematory Marley Neck
Location A. A. Co. Md.

18 (a) Funeral director Robert E. Williams
(b) Address 1510 McElderry St

19 (a) (Date received by registrar) NOV 19 1945 (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 13 1945 at 9:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19..., and that I last saw h alive on Nov 13 1945.

Immediate cause of death Uremia — Duration 2 wks
Due to Chronic Nephritis — ?
Due to Arteriosclerosis — ?
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. K. Adams M. D.
Address 1222 N. Caroline Date signed 11-15-45

correct age is especially important. Physicians: please write the ... Every item of information should be carefully supplied. The ... the causes of death clearly and legibly.

VS 150

G34175

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G34175
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: John Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dec.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1928 Eastern Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Arnold Bertschie (Bertsche

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Workman

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Andrew Cwalina
(b) Address 429 S. Chester St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-15-45 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location A.A. Co.

18 (a) Funeral director Wm. S. Frallerwork
(b) Address 2027 Eastern Ave

19 (a) NOV 15 1945 (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/13 1945, at 5:00 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 11/13/45

G34176

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G34176 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3721 Leo street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3721 Leo street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anthony Andrew Anuszewski (junyeski)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	married

6 (b) Name of husband or wife Cecilia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years	Months	Days	If less than one day
58			hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation Watchman
11. Industry or business Eastern Bod Vaporette

FATHER
12. Name John Anuszewski
13. Birthplace Poland

MOTHER
14. Maiden Name Catherine Jasinska
15. Birthplace Poland

16 (a) Informant Cecilia Anuszewski
(b) Address 3721, Leo st.

17 (a) Burial (b) Date thereof 11-17-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Balto City

18 (a) Funeral director Wm S. Fialkowski
(b) Address 2007 Eastern Ave.

19 (a) (b) NOV 15 1945
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-14- 1945, at 7A. M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary thrombosis.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) ~~Means of injury~~ Hugh B. McNally M.D

23. Signature Hugh B. McNally M.D.
Medical Examiner.
Date signed 11-14-45

G34177

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 14

G34177 Registered No.

correct age is especially important. Physicians: please write the ...ey item of information should be carefully supplied. The ...e the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address University
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 604 W. Mulberry Lt (If rural give location)
(e) Citizen of foreign country? S (Yes or No)
If yes, name country

3 (a) **FULL NAME** Queenie Elizabeth Wade

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1927 - Feb. 10

8. AGE: Years	Months	Days	If less than one day
18	9	-	hr. min.

9. Birthplace Bassette, Va. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Maurice Wade
13. Birthplace Rocky Mount, Va.

MOTHER
14. Maiden Name Annie May Brown
15. Birthplace Atkins S.C.

16 (a) Informant Cecilia Wade
(b) Address 604 W. Mulberry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 16 '45 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N Schroeder St

19 (a) (Date rec'd by registrar) (b) Registrar

NOV 15 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 10 1945, at 8:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 , to 19 , and that I last saw h alive on 19 .

Immediate cause of death respiratory paralysis — Duration

Due to meningitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James R. M. Smith Jr. M.D.
Address University Hosp. Date signed 11/10/45

James R. M. Smith

G34178

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 167

G34178 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give name)
(d) Street No. 500 N. Stricker St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John McKenny

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10, 1900

8. AGE: Years 45 | Months 5 | Days 29 | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name
13. Birthplace S.C.

MOTHER
14. Maiden Name
15. Birthplace S.C.

16 (a) Informant Mrs. Mary McKenny
(b) Address 509 N. Carey St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 15 '45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 W. Schroeder Ld.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 9, 1945 at 11:25 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Stab wound, left chest, and entering the

Due to heart.

Other Condition Stab wound, upper left arm, Fracture of upper left humerus.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-9-45 at 9:30 P. M.
(b) Where did injury occur? 500 N. Stricker Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home. While at work? No.
(d) Means of injury Stabbing

23. Signature Bernard Shetarchic M.D.
Medical Examiner.
Date signed November 10, 1945.

VS 151

G34179

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

115c

G34179 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts. #
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 21 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1007 W. Mulberry St. # 23.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Callie Robinson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: colored | 6 (a) Single, married, widowed, or divorced: married.

6 (b) Name of husband or wife: Rubin Robinson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 18, 1905

8. AGE: Years: 40 | Months: 1 | Days: 26 | If less than one day: hr. min.

9. Birthplace North Carolina. (Town, county, and state)

10. Usual Occupation Housewife.

11. Industry or business

FATHER
12. Name Isaac Jordon
13. Birthplace North Carolina.

MOTHER
14. Maiden Name Frances Boone
15. Birthplace North Carolina.

16 (a) Informant Rubin Robinson.
(b) Address 1007 W. Mulberry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 17 '45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Wallace
(b) Address 322 N. Schroeder St

19 (a) (Date rec'd by registrar) (b) Huntington Wilson Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 13 1945, at 12 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 12 1945 to Nov 13 1945 and that I last saw h[illegible] alive on Nov 13 1945.

Immediate cause of death Respiratory Failure

Due to Tympanal Edema + Aspiration (?)

Due to Peritonsillar Abscess - extending to face & neck

Other Conditions Anesthesia (Ether)

(Include pregnancy within 3 months of death)

Date of operation Nov. 12, 1945

Major findings of operation: Peritonsillar Abscess - left, extending to pectoral

of autopsy:

Duration - 8-10 min
4 hr ?
2 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature P. P. Zeigler M.D.
Address Mercy Hosp. Date signed 11/13/45 M. D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34180

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G34180 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 813 N. Bruce St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 813 Bruce St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ella A Hall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Colored	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 4, 1906.

8. AGE: Years	Months	Days	If less than one day
39	5	9	hr. min.

9. Birthplace Covington, Ga.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

MOTHER + FATHER

12. Name Rev. Wm. Henry Hall,
13. Birthplace Dawson, Ga.
14. Maiden Name Martha A. Davis
15. Birthplace Coleman, Ga.

16 (a) Informant Mrs. Minnie Lee Cooper,
(b) Address 634 N. Fulton Ave.

17 (a) Burial (b) Date thereof Nov. 17 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arlington Memorial
Location

18 (a) Funeral director Mrs. Katie Williams
(b) Address 322 N. Schroeder St. Hunting Ton Hotel Baltimore, Md.

19 (a) NOV 15 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/13- 1945 - at 3:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/10 1945 to 11/13 1945 and that I last saw her alive on 11/13 1945

Immediate cause of death	Duration
Lobar Pneumonia	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 714 Date signed 11/15/45

VS 100

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

34181

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

512

Registered No. G34181

Physicians: please write the causes of death clearly and legibly. Item or information should be carefully supplied. Every item is especially important. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 905 Washington Blvd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 905 Washington Blvd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HENRY JOHN STEMLER

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 212-07-1618

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Jennie M. Stemler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 24, 1880

8. AGE: Years	Months	Days	If less than one day
65	2	19	hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation Shipping Clerk
11. Industry or business Minch & Eisenbrey

FATHER
12. Name John Stemler
13. Birthplace Hagerstown, Md.

MOTHER
14. Maiden Name Emma Michel
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Jennie M. Stemler
(b) Address 905 Wash. Blvd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/16/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 15 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 13, 1945 at 1:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 11 1945 to Nov 13 1945
and that I last saw [illegible] alive on Nov 13 1945

Immediate cause of death: Carcinoma of Prostate — Duration 1 2 yrs

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury —

23. Signature [signature] M. D.
Address 76 Abell St Date signed X 11 | 14 | 45

VS 150

G34182

BALTIMORE CITY HEALTH DEPARTMENT

HEP #97154

CERTIFICATE OF DEATH 13B

G34182 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 56 - 2 & 27

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County 5
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1249 N. Bantalou St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Milton Blizzard

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 16, 1889

8. AGE: Years	Months	Days	If less than one day
56	2	27	hr. min.

9. Birthplace Balto Maryland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Baltimore City

FATHER
12. Name Elijah Blizzard (D)
13. Birthplace Carroll C Md.

MOTHER
14. Maiden Name Annie M Booker
15. Birthplace Carroll Co Md.

16 (a) Informant Balto. City Hospitals Records
(b) Address 4940 Eastern Avenue

17 (a) ~~Bur~~ Burial (Burial, cremation, or removal) (b) Date thereof Nov. 16, 1945 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore

18 (a) Funeral director Wm. J. Tickner & Sons,
(b) Address North & Pa. Aves.
(c) NOV 15 1945 (Date rec'd by registrar) (d) Huntington Williams Funeral Director

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 13, 1945 at 3:30P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 7, 1945 to Nov. 13, 1945 and that I last saw h im alive on Nov. 13, 1945

Immediate cause of death	Duration
Pulmonary Tuberculosis	2
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herbert B. Copeland Jr. M. D.
Address Balt. City Hosp Date signed 11/14/45

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34183

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1/31a

Registered No. G34183

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: University Hosp. 2

(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 418 Lanvale St
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME James Washington

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	—

6 (b) Name of husband or wife.....

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years	Months	Days	If less than one day
73			hr. min.

9. Birthplace V (Town, county, and state)

10. Usual Occupation.....

11. Industry or business

FATHER
12. Name.....
13. Birthplace

MOTHER
14. Maiden Name.....
15. Birthplace

16 (a) Informant Undertaker
(b) Address

17 (a).....(b) Date thereof 11-16-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cemetery
Location Balto.

18 (a) Funeral director Ralph B. Spriggs
(b) Address 139 W. Hamburg Street

19 (a) 11-15-1945 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 7, 1945, at 5:20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Renal Disease

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury.....at.....M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?.....While at work?.....
(d) Means of injury.....

23. Signature Benedict Skotarelic M.D.
Medical Examiner.
Date signed 11-9-45

G34184

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G34184
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Harford
(c) City or town Pylesville
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME Asa Shawbridge

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/20/1909

8. AGE: Years	Months	Days	If less than one day
37	1	25	hr. min.

9. Birthplace Pylesville, Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Sherman Shawbridge
13. Birthplace Md.

MOTHER
14. Maiden Name Nora Sam Saint
15. Birthplace Md.

16 (a) Informant
(b) Address

17 (a) Burial (b) Date thereof 11-17-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Fawn Grove
Location Pennsylvania

18 (a) Funeral director H. Howard Hall
(b) Address Fawn Grove, Pa.

NOV 15 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 15 1945, at 1 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cardiorespiratory failure

Due to Diabetic coma
Pneumonia (lobar).

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skotarelic M.D.
Medical Examiner.
Date signed 11-15-45

G34185

Charles at Oakland St

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a Registered No. G34185

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 623 E Fort Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 H
(e) Length of stay in Baltimore (yrs., mos., or days) 32 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 30 Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 623 E Fort Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ellen Agnes Willis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex female

5. Color or race white

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Clement A Willis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 31-1885

8. AGE: Years 60 | Months 9 | Days 13 | If less than one day hr. min.

9. Birthplace Salem N J
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Wm S Stevenson
13. Birthplace New Jersey

MOTHER
14. Maiden Name Catherine Egan
15. Birthplace Ireland

16 (a) Informant Mr Clement A Willis
(b) Address 623 E Fort Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 17-45 (month) (day) (year)
(c) Cemetery or crematory Holy Cross Cemetery
Location Gov. Ritchie Highway

18 (a) Funeral director Milton Schilling
(b) Address 3914 S Hanover St.

NOV 15 1945 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 13 1945, at 11:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 15 1945 to Nov 13 1945, and that I last saw h alive on Nov 13 1945

	Duration
Immediate cause of death Coronary Thrombosis	1 day
Due to Arteriosclerosis	
Due to Hypertension	1 year
Other Conditions Coronary Occlusion	8 yrs

(Include pregnancy within 3 months of death)

PHYSICIAN

Date of operation

Major findings of operation:

of autopsy:

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Isaac Miller M. D.

Address 1225 Cleveland St Date signed X 11/14/45

VS 180

Write the causes of death clearly and legibly.

634186

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

634186 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address LANVALE & Dukeland St.
(c) Hospital or institution:
West Baltimore Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 404 S. Payson St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helen Watson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Robert D Watson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 30, 1893

8. AGE: Years 52 | Months 4 | Days 14 | If less than one day ____hr. ____min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Edward M. Bruce
13. Birthplace —

MOTHER
14. Maiden Name
15. Birthplace —

16 (a) Informant Robert D. Watson
(b) Address 404 S. Payson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/17/45 (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3801 Frederick Rd

18 (a) Funeral director Harry W. Witzke
(b) Address 410 Edmondson Ave.

19 (a) (Date received) NOV 15 1945 Huntington Millersville, Md.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/14 1945, at 2:00 A.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Hypertensive Cardio-Vascular Disease

Due to

Other Conditions Polycythemia Vera

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Hugh B. McAulay Medical Examiner.

Date signed 11/19/45

G34187 | BALTIMORE CITY HEALTH DEPARTMENT | G34187

CERTIFICATE OF DEATH √159

File No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Walbrook & Catao Ave.
(c) Hospital or institution: St Agnes Hospital 1
(d) Length of stay in hospital or inst. (yrs., mos., or days) Born
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 33 S. Carey St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Semmont

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-14-45

8. AGE: Years | Months | Days | If less than one day: hr. 15 min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Travers W. Semmont
13. Birthplace Balto Md.

MOTHER
14. Maiden Name Dorothy Billingsley
15. Birthplace Md.

16 (a) Informant Mr Travers W Semmont
(b) Address 33 S. Carey St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/15/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem
Location 4300 Old Frederick Road.

18 (a) Funeral director John Cosgrove Son
(b) Address 9003 Baltimore St

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

NOV 16 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-14 1945 at 6:08 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-14 1945 to 11-14 1945.
and that I last saw him alive on 11-14 1945.

Immediate cause of death: Hyaline Membrane Disease — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. D. Williams Jr M. D.
Address Huntington Williams, M.D. Date signed 11/15/45

correct age is especially important. Physicians; please write the causes of death clearly and legibly.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34188 (1) BALTIMORE CITY HEALTH DEPARTMENT G34188
CERTIFICATE OF DEATH 194a Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2 Fayette & Chapel Sts.
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 D
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 201 Belvedere Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sara Clark

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex female | 5. Color or race white | 6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years 57 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation house work
11. Industry or business at home

FATHER 12. Name John Clark
13. Birthplace Bltd Md

MOTHER 14. Maiden Name Unknown
15. Birthplace Baltimore Md

16 (a) Informant Mrs Albert A Kennedy
(b) Address 110 N. Monroe St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 11 17 45 (month) (day) (year)
(c) Cemetery or crematory New Catholic Cem
Location 3300 Old Frederick Road

18 (a) Funeral director John J Connor & Son
(b) Address 901 Fulton Ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150 NOV 15 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-15 1945, at 4:42 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-12 1945, to 11-15 1945, and that I last saw h[illegible] alive on 11-15 1945.

Immediate cause of death	Duration
Coronary Thrombosis	3 Days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard C. Hayden M. D.
Address Bon Secours Date signed 11-16-45

X

G34189

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G34189 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2900 Dunmore Road
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 days.
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Dundalk (If outside city or town limits, write RURAL and give town)
(d) Street No. 2900 Dunran Rd (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth M. Blake

3 (b) If veteran, name war: none

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Divorced

6 (b) Name of husband or wife ? William F. Blake
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 17, 1882

8. AGE: Years	Months	Days	If less than one day
63	2	28	hr. min.

9. Birthplace Massachusetts (Boston) (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name P. J. McKenna (D)
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary E. Egan (D)
15. Birthplace Massachusetts

16 (a) Informant Mr. J. Howard Blake
(b) Address 2900 Dunran Rd.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11/16/45 (month) (day) (year)
(c) Cemetery or crematory Milton
Location Milton, Mass.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

NOV 17 1945 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/15/1945, at 3:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/28/1945 to 11/15/1945 and that I last saw her alive on 11/15/1945.

Immediate cause of death	Duration
Chronic cardiac failure	
Due to Hypertensive cardio-vascular disease.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 0
Major findings of operation:
of autopsy: 0

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature J. Frank Supplee, MD
Address Union Memorial Hospital Date signed 11/15/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34190

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G34190 Registered No. 186a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 406 N. Caroline St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Payne

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 17, 1900

8. AGE: Years	Months	Days	If less than one day
45	1	25	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Henry Bowdrey
13. Birthplace Maryland

MOTHER
14. Maiden Name Sarah Baddy
15. Birthplace Maryland

16 (a) Informant Eddie Payne
(b) Address 406 S. Carolina Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/16/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Bryant Ley ave

19 (a) (b) Huntington Williams, M.D.

NOV 15 1945

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH, November 12, 1945, at 2:40 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his... death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Concussion of Brain

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Nov. 12 1945 5 P M.
(b) Where did injury occur? 406 N. Carolina St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Fall downstairs

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed 11-12-45

G34191

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1579

G34191 Registered No.

Please answer questions 1 to 23 in full. Use ditto marks (") where they apply. Where information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Carrollie + Hoffman
(c) Hospital or institution:
St. Joseph's Hosp. 6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 days

2. USUAL RESIDENCE OF DECEASED:
(a) State 6 Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 428 N. Clinton St - 2d
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Wayne Page Johnson

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov. 10 - 1945

8. AGE: Years | Months | Days 5 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Newborn Baby
11. Industry or business

FATHER
12. Name Woody Johnson
13. Birthplace Detroit, Mich.

MOTHER
14. Maiden Name Alma June Harrison
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs Alma Johnson
(b) Address 428 N. Clinton St - 2d

17 (a) Burial (b) Date thereof Nov. 16, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Moreland Memorial Park
Location Taylor Ave.
18 (a) Funeral director John F. Denny, Inc.
(b) Address 715 Light St.
19 (a) Date received (b) Registrar
NOV 15 1945
Huntington Williams, M.D.
Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 14 1945 at 4:50 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 10 1945 to Nov. 14 1945 and that I last saw h Lm alive on Nov. 14 1945

Immediate cause of death Respiratory failure — Duration
Due to Pulmonary congestion
Due to Congenital defect of G-I tract
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank J. Lidz Jr. M.D.
Address St. Joseph's Hospital Date signed 11/15/45

G34192 G34192

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 33a

Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3101. Foster ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3101. Foster ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Calvin Raymor - Rayner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male. | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Edith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 5 1880

8. AGE: Years 66 | Months 1 | Days 9 | If less than one day hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation Bake Cut.

11. Industry or business

FATHER 12. Name William Rayner

13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Isabelle Stringfellow

15. Birthplace Balto Md

16 (a) Informant James H. Rayner

(b) Address 7309 Marshfield Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 17-45 (month) (day) (year)

(c) Cemetery or crematory Oak Lawn

Location Eastern Ave

18 (a) Funeral director Wendell Russell

(b) Address 3125 Hoffman Ave

19 (a) NOV 15 1945 (Date received by local registrar) Huntington Williams M.D.

VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH November 13th 1945, at 3 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-10th 1945 to 11-13th 1945, and that I last saw h alive on 11-12-45 1945.

Immediate cause of death Heart - Insufficiency

Due to Old Thr. Occlusion

Due to acute Grippe

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
2
1

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lore Trapnell, M. D.

Address Lombard & Hoffman Date signed 11-13-45

G34193

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G34193
Registered No.

Please write plainly in ink or use typewriter. Information should be carefully supplied. Be sure age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Mulberry & Payson
(c) Hospital or institution:
West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 45 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County --------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5500 Merville Avenue
(If rural give location)
(e) Citizen of foreign country? -------- (Yes or No)
If yes, name country --------

3 (a) FULL NAME Lillian M Richards

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife James R. Richards,
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) May 28, 1880

8. AGE: Years 64 | Months 5 | Days 17 | If less than one day -- hr. --- min.

9. Birthplace York, Pennsylvania
(Town, county, and state)

10. Usual Occupation None

11. Industry or business -----

FATHER
12. Name Samuel O. Malin
13. Birthplace Chester Co., Pa.

MOTHER
14. Maiden Name Hannah Hardcastle
15. Birthplace Pennsylvania

16 (a) Informant James R. Richards, Jr.
(b) Address 5500 Merville Avenue

17 (a) Burial (b) Date thereof 11/17/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director H. W. Meads and Son
(b) Address 805 N. Calvert Street

19 (a) 11 15 1945 (b) Huntington Williams M.D.
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-15 1945, at 7:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-10 1945 to 11/15 1945.
and that I last saw her alive on 11-15 1945

Immediate cause of death	Duration
Thrombosis Coronary artery cardiac infarction	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Alone & Clinical

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lucille Baldwin, M.D.
Address West Baltimore General Hospital Date signed 11/15/45

VS 150

G34194 BALTIMORE CITY HEALTH DEPARTMENT G34194
CERTIFICATE OF DEATH 1124 B Registered No.

Please write the information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27 E Crowell
(c) Hospital or institution: 23

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 27 E Crowell St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Manning

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	White	Married

6 (b) Name of husband or wife Jennie Miller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug - 1886.

8. AGE: Years	Months	Days	If less than one day
59	3 2	3	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Retail Grocer
11. Industry or business

FATHER
12. Name Martin Manning
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret Dright
15. Birthplace Ireland

16 (a) Informant Mrs Leigh Kerr
(b) Address 27 E. Crowell St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/16/45 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Old Frederick Rd

18 (a) Funeral director J. J. Daley & Sons
(b) Address 121 S Eutaw St.

NOV 15 1945
(Date rec'd by registrar) (b) Signature Thurlington Williams, Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH November 13 1945, at 2 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 10 1945 to Nov 13 1945 and that I last saw h[illegible] alive on Nov 12 1945.

Immediate cause of death	Duration
(a) Cerebral Hemorrhage	
Due to	
Due to	
Other Conditions Arteriosclerosis & Hypertension	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature John G. Scheurich, M. D.
Address 1367 S. Charles St. Date signed 11/14/45

X

G34195

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46D

Registered No. G34195

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-0-0
(e) Length of stay in Baltimore (yrs., mos., or days) 19 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 621 N. Paca St.
(If rural give location)
Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James A Bartow

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Lucille Bartow

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 25 1876

8. AGE: Years	Months	Days	If less than one day
69	6	18	hr. min.

9. Birthplace Savannah Ga
(Town, county, and state)

10. Usual Occupation Waiter

11. Industry or business

FATHER
12. Name James Bartow
13. Birthplace Savannah Ga

MOTHER
14. Maiden Name Clara Houston
15. Birthplace Savannah Ga

16 (a) Informant Lucille Bartow
(b) Address 621 N Paca St

17 (a) Burial (b) Date thereof 11-18-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Ga
Location Savannah Ga

18 (a) Funeral director Mrs Frances A Hemsley
(b) Address 578 W Biddle St

19 (a) (b) Registrar

NOV 16 1945 Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 13, 1945, at 2:30 P. M

21. I certify that I took charge of the remains described above, held an Inspection & Inquest thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Carcinoma of the Rectum with metastases.
Due to Emaciation, marked.
Ascites.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Stalarlie M.D.
Medical Examiner.
Date signed November 13, 1945.

G34196

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46a ✓

Registered No. G34196

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address (If not in hospital or institution) Homestead & Green
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 16
(e) Length of stay in Baltimore (yrs., mos., or days) 67 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balt.
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 404 E. 31st St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John C. Spedden

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Alice F.

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) July 3rd 1878

8. AGE: Years 67 | Months 4 | Days 12 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Architect

11. Industry or business Self - O.P.A.

FATHER
12. Name Thomas G. F. Spedden
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Lydia E. Auld.
15. Birthplace Md.

16 (a) Informant Son
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/19/45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location " Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

(Date received by Registrar) (b) Registrar

NOV 10 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 - 15 1945 at 6.45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-6 1945 to 11-15 1945 and that I last saw h~~im~~ alive on 11-14 1945.

Immediate cause of death Probable pulmonary embolism

Due to CA of Oesophagus.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 11-5-45

Major findings of operation: CA of lung

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature G. P. Feeney M. D.
Address Univ. Hosp. Date signed 11-15-45

VS 150

X

Please write plainly with pen or indelible pencil. Items of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

AB-97198 G34197 BALTIMORE CITY HEALTH DEPARTMENT ✓ G34197
Registered No.

CERTIFICATE OF DEATH 13B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5days
(e) Length of stay in Baltimore (yrs., mos., or days) 5yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1668 Bruce Ct.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Lewis

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Blanche
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1-1916

8. AGE: Years	Months	Days	If less than one day
29	5	13	hr. min.

9. Birthplace N.C.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Hanna Lewis
13. Birthplace N.C.

MOTHER
14. Maiden Name Maggie McKay or McKoy
15. Birthplace N.C.

16 (a) Informant Baltimore City Hospitals (Record
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-17-45 (month) (day) (year)
(c) Cemetery or crematory
Location Elysian Town N.C.

18 (a) Funeral director Hamb. W. Chase & Son
(b) Address 638 N. Gilmor St.

19 (a) NOV 1 (Date received by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

28. DATE OF DEATH Nov. 14- 1945 at 3.25P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-9- 1945 to 11-14 1945, and that I last saw him alive on 11-14 1945

Immediate cause of death Pulmonary Tuberculosis — Duration ?
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert B. Copeland Jr. M.D.
Address Balt. City Hosp. Date signed 11/15/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34198

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

G34198 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2312 E. Eager St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Novotny NOVOTNY

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Antonia Deceased
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 2, 1863

8. AGE: Years 82 | Months 8 | Days 1 | If less than one day hr. min.

9. Birthplace Czechoslovakia (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace " "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Nibla Josha.
(b) Address 845 N Patterson Park Ave.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 11/16/45 (month) (day) (year)
(c) Cemetery or crematory Oak Hill
Location Hoffman's Lane

18 (a) Funeral director C. Schuppmond
(b) Address 768 E. Madison St.

19 (a) (b) Huntington Williams

NOV 16 1945

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 13 1945, at 11:30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Edema of Brain, traumatic; Fracture of Base

Due to

Other Conditions Generalized arteriosclerosis, marked.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury November 13 1945 7/3 M.
(b) Where did injury occur? 2312 E. Eager St
(c) Did injury occur at home, on farm, industrial place, in public place? at home While at work? No
(d) Means of injury Fall down stairs

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed 11-13-45

G34199

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

G34199 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 831 N. Milton Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 1/2
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 831 N. Milton Avenue
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME John T. Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mary (nee Wacek)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 14, 1875

8. AGE: Years 70 yrs. | Months 1 | Days - | If less than one day ... hr. ... min.

9. Birthplace: Baltimcre, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business: Baltimore News-Post

FATHER
12. Name: unknown
13. Birthplace: "

MOTHER
14. Maiden Name: [illegible] Myles
15. Birthplace: unknown

16 (a) Informant: Mary Johnson (wife)
(b) Address: 831 N. Milton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/16/45 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Belair Rd. Balto. Md.

16 (a) Funeral director: Charles E. Schimunek
(b) Address: 2601-03 E. Madison Street

19 (a) (Date received by registrar) NOV 16 1945 (b) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 14 1945, at 12:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 7 1945 to Nov 14 1945; and that I last saw deceased alive on Nov 14 1945.

	Duration
Immediate cause of death: Cachexia Carcinoma (Pylorie)	1 1/2 Years
Due to:	
Due to:	
Other Conditions: —	

(Include pregnancy within 3 months of death)

Date of operation Sept 14 - 1945

Major findings of operation: Cancer of Pylorus and of Stomach

of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence — at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? none (Specify type of place) While at work?
(e) Means of injury

23. Signature: L. L. Grady M.D.
Address 706 Hoiford Rd. M. D.
Date signed 11/15/45

VS 150

PLEASE WRITE LEGIBLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34200

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G34200 Registered No. 161C

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Provident
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1/2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town TURNER STA.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 819 Avondale Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Ralph Hansford Johnson.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race C. | 6 (a) Single, married, widowed, or divorced. Infant

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-13-45

8. AGE: Years | Months | Days 2 1/2 | If less than one day ... hr. ... min.

9. Birthplace Provident Hospital
(Town, county and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Mr. Ralph Wilson Johnson
13. Birthplace Virginia

MOTHER 14. Maiden Name Cathelia Tate
15. Birthplace Virginia

16 (a) Informant Mr. R. W. Johnson
(b) Address 819 Avondale Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/16/45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvery
Location

18 (a) Funeral director Elroy O Wilson
(b) Address 1000 Bryant Lee Blvd

19 NOV 16 1945 (Date rec'd by Registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-15 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-13 1945, to 11-15 1945, and that I last saw alive on 11-15 1945.

Immediate cause of death Anaemia & Pertonitis — Duration

Due to Ruptured RH Tube

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Huntington Williams, M.D.
Address 7138 Eastern Ave Date signed 11/16/45

Huntington Williams, M.D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34201

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G34201

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 1-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 820 S. Rose Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN PIECHOCKI (JOHN WALKER)

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-10-1852

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Angela

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 17, 1885

8. AGE: Years	Months	Days	If less than one day
60	3	29	hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Joseph Piechocki
13. Birthplace Poland

MOTHER
14. Maiden Name Agnes ? Gwozdziewski
15. Birthplace Poland

16 (a) Informant Angela Piechocki
(b) Address 820 S. Rose Street

17 (a) Burial (b) Date thereof 11-19-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Baltimore Md

18 (a) Funeral director George A Weber
(b) Address 705 S. Linn St
(c) NOV 16 1945 Huntingtown Millington Md
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 15, 1945, at 10:05 A. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary occlusion.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Sutarelli M.D.
Medical Examiner.
Date signed 11-15-45

G34202

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51B

G34202 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 416 N. Mosher St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 416 N. Mosher St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dr. Daniel C. Brown

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Katie L.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 2, 1868

8. AGE: Years 77 | Months 9 | Days 10 | If less than one day hr. min.

9. Birthplace Rockville, Va
(Town, county, and state)

10. Usual Occupation Dentist

11. Industry or business

FATHER
12. Name Spencer Brown
13. Birthplace Va.

MOTHER
14. Maiden Name Sidney ? ? ?
15. Birthplace Va

16 (a) Informant Mrs. Katie L. Brown
(b) Address 416 N. Mosher St.

17 (a) Burial (b) Date thereof Nov. 16, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Ephrata Mem. Pk.
Location Baltimore Co. Md.

18 (a) Funeral director Wm. Lee A. Stafford
(b) Address 1631 Druid Hill Ave.

19 (a) (b) Huntingtown, Williams, Md.
(Date received by registrar)

NOV 16 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 13 1945, at 6 05 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/18 1941 to Nov 13 1945 and that I last saw h... alive on 8. 12 1945

Immediate cause of death: Cancer Carcinoma

Due to: Carcinoma of Prostate

Due to:

Other Conditions: Ethanestrum

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration: 1 year

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. P. Stuyler M. D.
Address 825 N. Fremont Ave Date signed 11.15.45

X

correct age is especially important. Physicians: please write the

G34203 BALTIMORE CITY HEALTH DEPARTMENT G34203

CERTIFICATE OF DEATH 1131a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1928 Brunt St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14-3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1928 Brunt St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George Junius Dudley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Colored

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Arlean

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 2, 1895

8. AGE: Years 50 Months 6 Days 16 If less than one day hr. min.

9. Birthplace Newbern, N. C. (Town, county and state)

10. Usual Occupation Counter man

11. Industry or business

FATHER
12. Name Ceasar Dudley
13. Birthplace Newbern, N.C.

MOTHER
14. Maiden Name Eliza Burney
15. Birthplace Newbern, N.C.

16 (a) Informant Mrs. Arlean Dudley
(b) Address 1928 Brunt St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 16, 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Mrs. Lew. A. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) (b) (Registered by registrar)

NOV 16 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/13/1945, at 11:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/6/1945 to 11/13/1945 and that I last saw him alive on 11/13/1945.

Immediate cause of death Uremia Coma — Duration

Due to Hypertension

Cardiac - Renal Dumb

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wayland F. Jones

Address 1300 N. Broadway Date signed 11/15/45

Huntington Williams, M.D.

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34204
CHK-97240

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH V/24a

Registered No. G34204

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 8
(d) Length of stay in hospital or inst, (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days) 30 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1205 N. Bond Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Washington Smith

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Hannah Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25-1899

8. AGE	Years	Months	Days	If less than one day
45	46	10	17	hr. min.

9. Birthplace Georgia
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Jim Smith
13. Birthplace Georgia

MOTHER
14. Maiden Name Sally ?
15. Birthplace Georgia

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof 11/16/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location
18 (a) Funeral director Joseph B. Lockard
(b) Address 1126 N. Central Ave
19 (a) (Date rec'd by registrar) (b) Registrar

NOV 16 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH November 12 1945 at 11:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 11 1945, to Nov. 12 1945, and that I last saw him alive on Nov. 12 1945

Immediate cause of death	Duration
Pyelonephritis + Uremia	
Due to Cardiac decompensation	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation Autopsy refused
Major findings of operation: Lt. Kidney pyelonephritis Gangrene Cirrhosis
of autopsy: Chronic process; Complications

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Eugene Petorillet M. D.
Address B O H Date signed 11-13

Huntington Williams, M.D.
Petorillet X

95

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34205

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G34205 Registered No. 170c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution:
Maney Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) D. 0 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3437 Piedmont Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph J. Shine

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Mary A. Shine
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 9, 1883

8. AGE: Years	Months	Days	If less than one day
62	10	5	hr. min.

9. Birthplace Kirkwood, Mo.
(Town, county, and state)

10. Usual Occupation
11. Industry or business Baltimore City Employee

FATHER
12. Name Dennis Shine
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Driscoll
15. Birthplace Ireland.

16 (a) Informant Mr. Geo. E. Whorl
(b) Address 1492 Lakeview Ave., Wilmington Del.

17 (a) Burial (b) Date thereof 11/17/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (b)
(Date rec'd by registrar) (Registrar)

NOV 16 1945 Wilmington, Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 14 1945 at 7:25 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Comminuted
Fracture of Skull
Compound Comminuted Fracture
Due to Right Leg

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury November 14 1945 7:08 P.M.
(b) Where did injury occur? Saratoga & St. Paul Sts
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Struck by taxi

23. Signature Robert Lee Erickson M.D.
Medical Examiner.
Date signed 11-15-45

G34206

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓61

G34206 Registered No.

The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1 W. Heath St.
(c) Hospital or institution: 23
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 1 W. Heath St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Maggie Helen Kronenberg,

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Wm. John Kronenberg
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 27, 1881

8. AGE: Years	Months	Days	If less than one day
64	4	16	hr. min.

9. Birthplace Baltimore City, (Town, county, and state)
10. Usual Occupation Housewife,
11. Industry or business at home,

FATHER
12. Name George Kern,
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Deal,
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Wm. F. Kronenberg,
(b) Address 1 W. Heath St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/16/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore City,

18 (a) Funeral director La Vernon Lemmon.
(b) Address 4611 Park Heights Ave.

19 NOV 16 1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION A.

20. DATE OF DEATH Nov. 13, 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 10 1945 to Nov. 13 1945 and that I last saw her alive on Nov. 13 1945

Immediate cause of death: Acute dilatation of heart — Duration 2 Hs.
Due to: Pheumonia — 2 Ds.
Due to: Mental Deprivation — Indef.
Other Conditions: Diabetes.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature P. E. Campbell M. D.
Address 1644 Hanover St. Date signed

VS-150

G34207

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 61

G34207
Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly. The information should be correctly supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Mercy Hospital
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 3
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 3009 Kentucky Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Lillian-Lilie-Wilson Wiegroff

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) ~~Single~~, married, ~~widowed, or divorced~~ Widowed

6 (b) Name of husband or wife William Wiegroff

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 20 1875

8. AGE: Years 70 Months 3 Days 25 If less than one day hr. min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Geo W Clayton
13. Birthplace New Jersey

MOTHER
14. Maiden Name Matilda Dorsey
15. Birthplace Philadelphia

16 (a) Informant Francis St. Clayton
(b) Address 3009 Kentucky Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 17-45 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Balto

18 (a) Funeral director P F Stevenson
(b) Address 3009 Kentucky Ave

19 (a) NOV 16 1945 (Date rec'd by registrar) (b) Huntington Williamsport, Md Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 14 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 15 1937 to Nov 14 1945, and that I last saw h.e alive on Nov 14 1945.

Immediate cause of death Cerebral Embolism — Duration 15 m

Due to Coronary Thrombosis — years

Due to Hypertension —

Other Conditions Arterio-Diabetes — years

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry J Bigley M.D.
Address 1 W Eager St Baltimore Md Date signed Nov 16 45

VS 150

121a

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

D 34208

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

D 342.08 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4209 Potter Ave.
(c) Hospital or institution:
20
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4209 Potter Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Benno August Schulz

3 (b) If veteran, name war

3 (c) Social Security Account No. 23-03-6075

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	married

6 (b) Name of husband or wife Alice Schulz nee Roth
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 4, 1895

8. AGE: Years	Months	Days	If less than one day
50	9	10	hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation Ass't Controller
11. Industry or business Brager-Eisenberg

FATHER
12. Name August H. Schulz
13. Birthplace Germany

MOTHER
14. Maiden Name Elsie Schumacher
15. Birthplace Austria

16 (a) Informant Alice Schulz
(b) Address 4209 Potter Ave.

17 (a) Burial (b) Date thereof 11/17/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3801 Frederick Rd

18 (a) Funeral director Harry A. Wilkes
(b) Address 4914 Edmondson Ave

19 (a) NOV 17 1945 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 14 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 25 1944 to Nov 14 1945 and that I last saw h— alive on Nov 14 1945

Immediate cause of death (a) Chronic Nephritis

Due to

Due to

Other Conditions Chronic Pyelitis Bilateral Ureteritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration 8 yrs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. A. Lasky M. D.
Address 3513 Edmondson Ave Date signed Nov 15, 1945

VS 150

G34209

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. G34209

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1843 PENROSE AVE
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1843 PENROSE AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lottie O'Neil Briggs

3 (b) If veteran, name war

3 (c) Social Security Account No. ?

4. Sex FEMALE | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Richard Briggs

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JAN 15-1871

8. AGE: Years 74 | Months 10 | Days 0 | If less than one day hr. min.

9. Birthplace md
(Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER
12. Name Stoten OLIVER
13. Birthplace md

MOTHER
14. Maiden Name Catherine HAYDEN
15. Birthplace md

16 (a) Informant Bertha M. BROWN
(b) Address 44 6ye St N.W. Wash. D.C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof NOV 17-1945 (month) (day) (year)
(c) Cemetery or crematory NEW Cathedral
Location Pratt C. B.M. Walter City

18 (a) Funeral director Pratt Stricker Co
(b) Address

19 (a) NOV 16 1945 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 15 1945 at 12 05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 10 1945 to Nov. 14 1945, and that I last saw her alive on Nov. 14 1945.

Immediate cause of death Coronary Thrombosis. — Duration 2 days.

Due to Arterio Sclerosis —

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel E. Bogorad

Address 1905 W. Baltimore St. Date signed 11/15/45

VS 150

X

34210 HEP #96074

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G34210 Registered No. 13za

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 & 1
(e) Length of stay in Baltimore (yrs., mos., or days) 80-10-20

15-2

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1612 N. Monroe St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Theodore E. Geldmacher.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Sarah E. Geldmacher
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25, 1864.

8. AGE: Years	Months	Days	If less than one day
80	10	20	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Machinist helper.

FATHER
12. Name Frederick Geldmacher.
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth Meycratz
15. Birthplace Md.

16 (a) Informant Balto. City Hospitals Records
(b) Address 4940 Eastern Avenue

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof Nov. 19-'45 (month) (day) (year)
(c) Cemetery or crematory Mount Olivet Cem.
Location Baltimore - Md.

18 (a) Funeral director Charles J. Schwab.
(b) Address 505 N. Monroe St.

19 (a) (Date received by registrar) (b) Huntington Williams, M.D.

NOV 16 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 15, 1945, at 6:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 14, 1945, to Nov. 15, 1945, and that I last saw him alive on Nov. 15, 1945.

Immediate cause of death	Duration
(a) Uraemia	
+ Cardiosis	
Due to (b) generalized arteriosclerosis	
+ Senility	
Due to (c) + Hypertension and Sclerotic heart disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 10-25-45

Major findings of operation: benign hypertrophy of prostate

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Eugene Alvin Patoullet M. D.
Address B-C-H. Date signed 11-15-45

Patoullet

Please write the causes of death clearly and legibly. Physicians: please write age is especially important.

G34211

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G34211

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution:
John Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 729 N. Eden St
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME David Green

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Widower

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years	Months	Days	If less than one day
65			....hr. ....min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation None

11. Industry or business —

FATHER
12. Name unknown
13. Birthplace "

MOTHER
14. Maiden Name unknown
15. Birthplace "

16 (a) Informant Joseph Green
(b) Address 24 Dallas Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 16 45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location Anne Arundel Co, Md

18 (a) Funeral director Mrs Ida Bailey
(b) Address 1424 Jefferson St

NOV 16 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/13 1945, at 8 20 P M

21. I certify that I took charge of the remains described above, held an Inspection and Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Chronic Myocardial Degeneration
Due to /

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury.....at.....M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?.....While at work?.....
(d) Means of injury.....

23. Signature R. J. Pantuso M.D.
Medical Examiner.
Date signed 11/14/45

VS 151

G34212

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1170

Registered No. G34212

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ---
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 731 E. Preston
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Charles Phillips

3 (b) If veteran, name war: World War #2

3 (c) Social Security Account No. 215-10-6309

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: ---

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 28, 1908

8. AGE: Years 37 | Months 5 | Days 14 | If less than one day: hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Supervisor

11. Industry or business Glenn L. Martin

FATHER
12. Name Charles W. Phillips
13. Birthplace Penna.

MOTHER
14. Maiden Name Etta M. German
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Etta M. Phillips
(b) Address 731 E. Preston street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 16/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location

18 (a) Funeral director Chas. J. Evans Son Inc.
(b) Address 118 N. 9th. Royal Ave

19 NOV 16 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 12 1945, at 8.25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-8 1945 to 11-12 1945 and that I last saw him alive on 11-12 1945.

Immediate cause of death: Uremia

	Duration
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 11-3-45

Major findings of operation?

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. E. Wallace M. D.

Address 1400 W. Cold. St. Date signed 11/12/45

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34213

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G34213 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1341 Fremont Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2mo 4
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1341 Fremont Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ella E. Bond

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: James Bond
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr x ? 97

8. AGE: Years 48 | Months ? 7 | Days 9 | If less than one day: hr. min.

9. Birthplace Frederick Md.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Ellis Smallwood
13. Birthplace Frederick Md.

MOTHER
14. Maiden Name Ella Smathers
15. Birthplace Frederick Md.

16 (a) Informant Robert B Bond
(b) Address 1341 Fremont Ave

17 (a) Burial (b) Date thereof Nov. 18/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Brooklyn

18 (a) Funeral director Va Brotoks Rinaldi
(b) Address 1463 N. Carey St

19 (a) (Date rec'd by registrar) (b) (Registrar)
NOV. 16 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 13 1945; at 11.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 3 1945, to Nov 13 1945, and that I last saw her alive on Nov 13 1945.

Immediate cause of death Cardio Vascular Disease — Duration 1 yr.

Due to Workmen Compensation — 3 mo.th

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William Frey, M. D.
Address 1928 Pa Ave Date signed 11-15-45

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34214 | BALTIMORE CITY HEALTH DEPARTMENT | G34214

CERTIFICATE OF DEATH 186 | Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland (Maryland. Gen. Hosp.
(b) Street address
(c) Hospital or institution: Maryland General Hosp -
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto Co
(c) City or town Towson.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 409 Chesapeake Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. George Conway

3 (b) If veteran, name war ?
3 (c) Social Security Account No. ?

4. Sex: male
5. Color or race: White
6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Ella Kelly Conway
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 16, 1874

8. AGE: Years 71 | Months 0 | Days 29 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Retired Accountant
11. Industry or business C & P Tel. CO.

FATHER
12. Name Patrick Conway
13. Birthplace Ireland

MOTHER
14. Maiden Name Bridget
15. Birthplace Ireland

16 (a) Informant Mrs. Ella K. Conway
(b) Address 409 W. Chesapeake Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/19/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore

18 (a) Funeral director H. W. Meares and Son
(b) Address 805 N. Calvert Street

19 (a) (Date rec'd by registrar) (b) Huntington Williams Mgr.

NOV 16 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 15 1945, at 9:16 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-12 1945, to 11-15 1945 and that I last saw h/M alive on 11-15 1945

Immediate cause of death: Respiratory failure — Duration

Due to: Hypostatic Pneumonia

Due to: Displaced Cervical Vertebrae

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 9-27-45

Major findings of operation: Fracture dislocation 4th C-5 vertebrae

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 9-12-45 at 7 M
(c) Where did injury occur? [redacted] (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Fell down steps

23. Signature Augustus Th. Frye M.D.
Address 14 E. Hoop
Date signed 11-14-45

Approved: Robert L. Grafton M.D.

vs 100

...correct age is especially important. Physicians: please write the causes of death clearly and legibly.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34215

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

Registered No. G34215

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
U.S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) 16 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town Norristown
(If outside city or town limits, write RURAL and give town)
(d) Street No. 817 Green St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME ~~Smyth~~ James Bertram Smythe

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Mary E. Smythe
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Apr. 4, 1912

8. AGE: Years	Months	Days	If less than one day
33	7	12	....hr. ....min.

9. Birthplace Pa.
(Town, county, and state)
10. Usual Occupation Chief PhM
11. Industry or business Maritime Service

FATHER
12. Name Joseph Smythe
13. Birthplace N.J.

MOTHER
14. Maiden Name Mary Brown McCurdy
15. Birthplace Pa.

16 (a) Informant Records
(b) Address US Marine Hospital, Balto, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 20-45 (month) (day) (year)
(c) Cemetery or crematory Fort Kennedy Pa
Location Fort Kennedy Pa.
18 (a) Funeral director William Cook Inc
(b) Address 1217 St Paul St Balto Md.
19 (a) ..... (b) .....
(Date rec'd by registrar) Registrar

NOV 16 1945

MEDICAL CERTIFICATION A

20. DATE OF DEATH Nov. 16 1945, at 4:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 31 1945, to Nov. 16 1945, and that I last saw him alive on Nov. 16 1945.

Immediate cause of death	Duration
Endocarditis - chronic Rheumatic, mitral stenosis with Cardiac Failure and pulmonary	6 yrs
Due to infarction.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address Clinical Director Date signed 11/16/45

Huntington Williams M.D. (coa)
U. S. Marine Hospital, Balto., Md.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92D

G34216 (Registered No.) G34216

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 107 S. Washington St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 107 S. Washington St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John H. Endres

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: Male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Theresa M. Grace
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 2, 185?

8. AGE: Years 88 | Months 1 | Days 14 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and State)

10. Usual Occupation retired tailor

11. Industry or business

FATHER
12. Name Frederick Endres
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret ?
15. Birthplace Germany

16 (a) Informant Marie Pilachowski
(b) Address 107 S. Washington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/19/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director M. W. E. Dippel's Sons
(b) Address Lombard & Ann Sts.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

NOV 16 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 16 1945 at 1:30 P.M.

21. I certify that death occurred on the date above stated: that I attended deceased from Jan. 1925 to Nov. 16 1945 and that I last saw him alive on Nov. 13 1945.

Immediate cause of death: Acute Cardio-Respiratory decompensation — Duration: days

Due to Chr. Myocarditis & Endocarditis — 10 yrs

Due to

Other Conditions Chr. Arteriosclerosis — 10 yrs.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]
Address 700 E. Fayette St. Date signed 11/16/45

X X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34217

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G34217
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 848 W 36th St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 848 W 36th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elsie M. Patterson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. widow.

6 (b) Name of husband or wife Joseph H. Patterson.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 31, 1866

8. AGE: Years 79 | Months - | Days 15 | If less than one day hr. min.

9. Birthplace Pennsylvania.
(Town, county, and state)

10. Usual Occupation Housework.

11. Industry or business

FATHER
12. Name Valentine Klinepeter
13. Birthplace Pa.

MOTHER
14. Maiden Name Mary ?
15. Birthplace Pa

16 (a) Informant Mrs. Lola Ford.
(b) Address 848 W 36th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 17/45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville

18 (a) Funeral director Chenoweth & Donovan
(b) Address 3615-17 Chestnut Ave.

19 (a) (Date rec'd by registrar) NOV 16 1945 (b) Huntington-Williamson Mort. 848 W. 36th St.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 15, 1945, at 2:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 2 1942 to Nov 15 1945. and that I last saw her alive on Nov 15 1945.

	Duration
Immediate cause of death Pulmonary Oedema	1 hour
Due to Heart failure	2 days
Due to Arteriosclerotic Heart Disease	15 years
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Leonard Wallenstein M.D.
Date signed 11/15/45

X

Physicians: please write the correct age is especially important. Every item of information should be carefully supplied. The causes of death clearly and legibly.

G34218

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

G34218 Registered No.

Type the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1316 N. Mount St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1316 N. Mount St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Gates

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife none

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 1897

8. AGE: Years 48 | Months 3 | Days | If less than one day hr. min.

9. Birthplace Ga (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Singleton Gates
13. Birthplace Ga.

MOTHER
14. Maiden Name —
15. Birthplace Ga.

16. (a) Informant Hattie Bowser
(b) Address 1316 N. mount St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/17/45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Md.

18 (a) Funeral director Wm. U. Nelson
(b) Address 1945 Pulaski

19 NOV 16 1945 (Date rec'd by registrar) (b) Huntingtown, Md.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 15th 1945, at 11 39 A.M.

21. I certify that I took charge of the remains described above, held an Insp + Inq: thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cardio vascular renal disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Malloy M.D.
Medical Examiner.
Date signed 11-15-45

G34219

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G34219 Registered No. 94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Ford Baltimore Hotel
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa (b) County Delaware
(c) City or town Springfield (If outside city or town limits, write RURAL and give town)
(d) Street No. Thompson Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John a. White

3 (b) If veteran, name war	3 (c) Social Security Account No.
-	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Margaret Penn White
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 15, 1894

8. AGE: Years	Months	Days	If less than one day
51	4	1	hr. min.

9. Birthplace Arkansas (Town, county, and state)
10. Usual Occupation Medical Director
11. Industry or business Penn. Railroad

FATHER
12. Name John a. White
13. Birthplace U.S.A.

MOTHER
14. Maiden Name Alice ???
15. Birthplace U.S.A.

16 (a) Informant Mrs. Margaret P. White
(b) Address Thompson Rd. Springfield, Pa.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11/16/45 (month) (day) (year)
(c) Cemetery or crematory
Location Philadelphia, Pa.

18 (a) Funeral director Wm. J. Tichnor & Sons
(b) Address No. 4 Penna. Ave. Balt. 1, Md.

19 (a) Date received by registrar NOV 16 1945 (b) Registrar Huntington Williams, Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-16-1945, at M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Malecio M.D.
Medical Examiner.
Date signed 11-16-45

✓ G34220

G34220

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46

Registered No. ....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4203 Grace Court.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days) ....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4203 Grace Court (If rural give location)
(e) Citizen of foreign country? .... (Yes or No)
If yes, name country ....

3 (a) FULL NAME Barbara Konopik. (KONOPIK.)

3 (b) If veteran, name war: no.

3 (c) Social Security Account No.:

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: late John Konopik

6 (c) If alive, give age .... years

7. Birth date of deceased (mo., day, yr.) Dec. 11/28/72.

8. AGE: Years: 73 | Months: 3 | Days: 17 | If less than one day: hr. .... min.

9. Birthplace Czechoslovakia (Town, county, and state)

10. Usual Occupation housewife.

11. Industry or business ....

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Blair, Herbert.
(b) Address 535 N. Belnord Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/17/45 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Annapolis Blvd.

18 (a) Funeral director C. Zimmerman
(b) Address 3601 E. Madison St.

19 (a) .... (Date rec'd by registrar) (b) .... Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 14 1945, at 8 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 2 1945 to Nov 14 1945, and that I last saw h[illegible] alive on Nov. 13 1945.

Immediate cause of death	Duration
(a) Acute Coronary Thrombosis	one day
Due to (b) Arterio-Sclerotic Cardio-Vascular Disease	
Due to (c)	
Other Conditions Probable Malignancy of Stomach (Include pregnancy within 3 months of death)	

Date of operation ....
Major findings of operation: none
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ....
(b) Date of occurrence .... at .... M
(c) Where did injury occur? .... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? .... While at work? .... (Specify type of place)
(e) Means of injury ....

23. Signature Emil Kahn M. D.
Address 320 Chesapeake Ave. Date signed 11/17/45

Huntington Williams, Registrar

DEC 6 1945

X

G34221

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered Number G34221

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) 4

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County ~~Kent~~ Caroline
(c) City or town Goldsboro
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Louise Bright
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Single
6 (b) Name of husband or wife None
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Feb. 15 1930
8. AGE: Years 15 | Months 9 | Days 1 | If less than one day hr. min.
9. Birthplace Goldsboro Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Arthur Bright
13. Birthplace Maryland

MOTHER
14. Maiden Name Lola Hughes
15. Birthplace Maryland

16 (a) Informant Arthur Bright
(b) Address Goldsboro Md.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 / 19/45 (month) (day) (year)
(c) Cemetery or crematory Greensboro
Location Greensboro Md.
18 (a) Funeral director R. B. Rawlings
(b) Address Greensboro, Md.
19 (a) NOV 17 1945 (Date received by registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH NOV 16 19 45, at 6 45 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from NOV 13 19 45 to NOV 16 19 45 and that I last saw her alive on NOV 16 19 45.

Immediate cause of death Hydrocephalus | Duration
Due to Unknown
Due to Unknown
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature J. W. Baggett M.D.
Address Greensboro Md. Date signed 11/16/45

VS 150

X

Please write plainly, with ONE ENTRY IN A SPACE. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34522

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52 B

Registered No. G34522

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3004 Auchentoroly Terr.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3004 Auchentoroly Terrace (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM PAUL HEIM

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Magdalena Heim
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25, 1869

8. AGE: Years	Months	Days	If less than one day
75	10	19	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Adam J. Heim
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Elizabeth Heller
15. Birthplace Germany

16 (a) Informant Mrs. Magdalena Heim
(b) Address 3004 Auchentoroly Terrace

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/17/45 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

NOV 17 1945 (date received by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 14, 1945, at 1:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 20 1945 to Nov 14 1945, and that I last saw h alive on Nov 13 1945.

	Duration
Immediate cause of death: General Carcinomatosis	3 Months
Due to: Carcinoma of Bladder	2 Years
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Elliot W. Johnson M. D.
Address 3432 Eutaw Pl. Balto. Md. Date signed

G34223
483534

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 44B

G34223
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3805 Park Heights Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Norma POLAND

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-1-25

8. AGE: Years	Months	Days	If less than one day
20	4	14	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Secretary.
11. Industry or business

FATHER
12. Name Myer Poland
13. Birthplace Russia

MOTHER
14. Maiden Name Sadie Goldfadden
15. Birthplace Md Baltimore

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov, 18, 1945 (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cem
Location Hamilton Ave Sharrei Zion
18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave
19 (a) (Person acting as undertaker) Huntington Wilkinson, M.D. (b) Address

NOV 17 1945

VS 100

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION P

20. DATE OF DEATH Nov. 15 1945, at 1030 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov-12 1945 to Nov. 15 1945 and that I last saw h.er alive on Nov-15 1945

Immediate cause of death	Duration
Cachexia + Anemia	
Due to Hodgkins Disease	9 mo
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Laurence Dochez M.D.
Address Johns Hopkins Hosp. Date signed 11/15/45

G34224

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1938

G34224 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 East Fayette Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2101 E. Fayette St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SARAH L. BAER

3 (b) If veteran, name war Sarah

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) ~~Single~~, married, ~~widowed, or divorced~~. Married

6 (b) Name of husband or wife George Baer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 16th 1880

8. AGE: Years 65 | Months 6 | Days 0 | If less than one day ..... hr. ..... min.

9. Birthplace ?
? (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name A. A. Giles
13. Birthplace Va.

MOTHER
14. Maiden Name Susan Almond
15. Birthplace Va.

16 (a) Informant George Baer
(b) Address 2105 E. Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/19/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem
Location Baltimore

18 (a) Funeral director Wm Cook Inc
(b) Address 1217 St Paul St

NOV 17 1945 Date received by Registrar — Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/16/45 19..... at 2:30 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury:

23. Signature John R. Davis, M.D. Medical Examiner.
Date signed 11/16/45

G34225

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V131a

G34225 Registered No.

Please write clearly and legibly. Use ink. Do not use pencil. Do not fold. Do not write outside the lines. If the cause of death is unknown, write "Unknown."

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Gen'l Hosp 22
(d) Length of stay in hospital or inst. (yrs., mos., or days) D. 9 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 728 S Hanover St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Daniel L. Rawsby

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 8, 1888

8. AGE: Years 57 | Months 1 | Days 7 | If less than one day hr. min.

9. Birthplace Calvert Co., Md (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Albert Rowsby

13. Birthplace Md

MOTHER 14. Maiden Name Minnie B. Mason

15. Birthplace Md

16 (a) Informant Mrs Sarah Gross

(b) Address 5037 N Arlington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-18-45 (month) (day) (year)

(c) Cemetery or crematory John Wesley Cem

Location Mutual, Calvert Co., Md.

18 (a) Funeral director Mrs. Frances A. Hemsley

(b) Address 578 W. Biddle St.

19 (a) NOV 17 1945 (Date received by Registrar) (b) Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 15 1945, at 1 20 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

Autopsy, Inspection or Inquiry

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular-renal disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Robert L. Gutas M.D.
Medical Examiner.

Date signed NOV 16 1945

G34226

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

Registered No. G34226

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Dorchester
(c) City or town Rhodesville
(If outside city or town limits, write RURAL and give town)
(d) Street No.....
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME William Mills Manning

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Gertrude E.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-28-75

8. AGE: Years	Months	Days	If less than one day
70	9	19	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name George Manning
13. Birthplace Md.

MOTHER
14. Maiden Name Dora Mills
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Nov 19 45 (month) (day) (year)
(c) Cemetery or crematory Washington
Location Maryland

18 (a) Funeral director P. Frampton & Son
(b) Address Todd Landing Md

NOV 17 1945 Huntingtown Williams, M.D.
(Date received) (Registrar's signature)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 16 1945; at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 26 1945, to Nov 16 1945 and that I last saw h[illegible] alive on Nov. 16 1945.

Immediate cause of death: Myocardial Insufficiency — Duration 8 hrs

Due to.....

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operation:.....

of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence.....at.....M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?.....While at work?.....
(Specify type of place)
(e) Means of injury.....
23. Signature Shirley Nimitt M. D.
Address.....Date signed Oct 16-45 JHH

correct age is especially important. Physicians: please write the causes of death clearly and legibly. The [illegible] of information should be carefully supplied. The

G34227

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V131a

G34227 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hospital 13-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2351 Druid Hill ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Carson Johnson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Katherine D Johnson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-7-1400

8. AGE: Years 45 | Months 5 | Days 8 | If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Physician

11. Industry or business

FATHER 12. Name James Johnson
13. Birthplace Md.

MOTHER 14. Maiden Name Anna Dodson
15. Birthplace Md.

16 (a) Informant Katherine Johnson
(b) Address 2351 Druid Hill ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/18/45 (month) (day) (year)
(c) Cemetery or crematory Mt Zion
Location Md. Meg. G. Nelson

18 (a) Funeral director
(b) Address 1303 Pleasant St

19 (a) (Date received by registrar) NOV 17 1945

Huntington for Baltimore, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-15 1945, at 1:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-10 1945 to 11-15 1945, and that I last saw h.i.m. alive on 11-15 1945.

Immediate cause of death Hypertensive cardiovascular renal disease — Duration 6 Months (Estimate)

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature B. J. Stateler
Address 1715 Park Date signed 11/17/45

correct age is especially important. Physicians: please write the the causes of death clearly and legibly.

G34626 (over) G34626

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4708 Amberly Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4708 Amberly Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANCES CORBI

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Vito Corbi
6 (c) If alive, give age 1874 years

7. Birth date of deceased (mo., day, yr.) Feb. 21, ~~1891~~

8. AGE: Years	Months	Days	If less than one day
66 ~~75~~	8	24	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Catanzariti
13. Birthplace Italy

MOTHER
14. Maiden Name Mary Ann
15. Birthplace Italy

16 (a) Informant Mr. Pasquale Corbi
(b) Address 616 E. Baltimore St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/19/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

NOV 17 1945 Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 15, 1945, at 7:20 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 14 1945 to Nov 15 1945, and that I last saw her alive on Nov 15 1945.

Immediate cause of death	Duration
Coronary Thrombosis	1 day
Due to Cardio Vascular Disease	7 years
Due to	
Other Conditions Diabetes Mellitus	12 years

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Elisha W Johnson M. D.
Address 3432 Sudbrook Lane Date signed

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

93D

G34229

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G34229 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 820 S Kenwood Ave
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 820 S Kenwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Paul C. Bennett

3 (b) If veteran, name war

3 (c) Social Security Account No. 232-26-4877

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Esther

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 15 1872

8. AGE: Years 73 | Months 10 | Days 1 | If less than one day hr. min.

9. Birthplace New Florence Pa. (Town, county, and state)

10. Usual Occupation Truck Checker

11. Industry or business

FATHER
12. Name Dixon Bennett
13. Birthplace New Florence Pa.

MOTHER
14. Maiden Name Nancy Clark
15. Birthplace ?

16 (a) Informant Esther Bennett
(b) Address 829 S. Kenwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/20/45 (month) (day) (year)
(c) Cemetery or crematory Greenway Cemetery
Location Berkeley Springs W. Va.

18 (a) Funeral director John D. Duda
(b) Address 2829 Hudson St.

19 (a) (b)

NOV 17 1945 Hearing for Baltimore, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 16 1945, at 3:30 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 14 1945, to Nov 16 1945, and that I last saw h[illegible] alive on Nov 16 1945.

Immediate cause of death	Duration
Arteriosclerotic C.V. Disease	
Chronic Bronchitis	10-14-45
Due to Complete Coronary Occlusion	11-16-45
Due to	
Other Conditions None	

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence None at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. A. Schumacher M. D.
Address 842 S Eaton Date signed 11-16-45

G34230 — BALTIMORE CITY HEALTH DEPARTMENT — G34230

CERTIFICATE OF DEATH

74a — Registered No.

Please write plainly with pen or pencil. Physicians: please write the causes of death clearly and legibly. Information should be carefully supplied and correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 42 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Cockeysville
(If outside city or town limits, write RURAL and give town)
(d) Street No. ---------
(If rural give location)
(e) Citizen of foreign country? ------ (Yes or No)
If yes, name country ------

3 (a) FULL NAME Sally Redd

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S.

6 (b) Name of husband or wife ---------
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) Oct. 5, 1942

8. AGE: Years	Months	Days	If less than one day
3	1	11	____ hr. ____ min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation --------
11. Industry or business --------

FATHER
12. Name Mr Carl Redd
13. Birthplace Alabama

MOTHER
14. Maiden Name Ruth Humber
15. Birthplace North Carolina

16 (a) Informant Carl L. Redd
(b) Address Cockeysville, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/18/45 (month) (day) (year)
(c) Cemetery or crematory Sherwood P. E.
Location Cockeysville, Md.

18 (a) Funeral director H. W. Mears and Son
(b) Address 805 N. Calvert Street

19 (a) Filed by registrar NOV 17 1945 (b) Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-16 1945, at 11:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from ____ 19__, to ____ 19__, and that I last saw h__ alive on ____ 19__.

Immediate cause of death: Leukemia Anemia — Duration: 1 mo.
Due to: Leukemia — Duration: 2 mo.
Due to: ____
Other Conditions: ____
(Include pregnancy within 3 months of death)
Date of operation ____
Major findings of operation: ____
of autopsy: ____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ____
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? ____ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ____ While at work? ____ (Specify type of place)
(e) Means of injury ____

23. Signature Mary Streeter M. D.
Date signed 11-17 Union Memorial

G34231 — BALTIMORE CITY HEALTH DEPARTMENT — G34231

CERTIFICATE OF DEATH 122a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden Ave. & Madison St.
(c) Hospital or institution: Maryland General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1334 Webster St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Thomas P. McNamee

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Edith M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 14 - 1880

8. AGE: Years 65 | Months 0 | Days 1 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business

FATHER — 12. Name James McNamee — 13. Birthplace Ireland

MOTHER — 14. Maiden Name Anna [illegible] Cummings — 15. Birthplace Ireland

16 (a) Informant Mrs Edith McNamee

(b) Address 1334 Webster St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-19-1945 (month) (day) (year)

(c) Cemetery or crematory Cathedral

[illegible] Baltimore Md.

18 (a) Funeral director Flynn & Fleming

(b) Address 1476 Light St.

[illegible] Barnhart Williams, M.D. Registrar

(Signature of Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/15 1945 at 8:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/19 1945 to 11/15 1945 and that I last saw him alive on 11/14 1945

Immediate cause of death CONGESTIVE HEART FAILURE — Duration 10/19/45 11/15/45

Due to HYPERTENSIVE HEART DISEASE

Due to

Other Conditions RT. INGUINAL HERNIA (Include pregnancy within 3 months of death)

Date of operation 10/19/45

Major findings of operation: INCARCERATED HERNIA

of autopsy: —

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles W. Stewart, Jr. M. D.

Address Md. Gen. Hosp. Date signed 11/15/45

PHYSICIAN

Underline the cause to which death should be charged statistically.

correct age ... especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G34232 G34232

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 90 B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1821 Covington Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John B. Doyle

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years 49 | Months | Days | If less than one day ____hr. ____min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Michael F. Doyle
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Mary Foley
15. Birthplace Baltimore Md

16 (a) Informant Michael F. Doyle
(b) Address 1971 Covington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof NOV. 20, 1945 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore Md
Funeral director Flynn & Hennig
(b) Address 1426 Leadenhall St. (Huntington Williams Hall)

NOV 18 1945
NOV 17 1945
NOV 18 1945

MEDICAL CERTIFICATION 43

20. DATE OF DEATH November 17, 1945, at 12 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute pericarditis with effusion; Anasarca

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Forster M.D. (Medical Examiner.)
Date signed Nov 17 1945

G34233 BALTIMORE CITY HEALTH DEPARTMENT G34233

CERTIFICATE OF DEATH 170c

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2118 N. Calvert Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Richard Bennett

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	Married

6 (b) Name of husband or wife Pauline
6 (c) If alive, give age 21 years

7. Birth date of deceased (mo., day, yr.) Dec. 9 - 1923

8. AGE: Years	Months	Days	If less than one day
21	11	11	hr. min.

9. Birthplace W. Va (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Philip E. Bennett
13. Birthplace W. Va

MOTHER
14. Maiden Name Maggie Judy
15. Birthplace W. Va

16 (a) Informant Mrs Pauline Bennett
(b) Address 2118 [redacted] N. Calvert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-17-1945 (month) (day) (year)
(c) Cemetery or crematory
Location Arlington W. Va

18 (a) Funeral director Flynn & Flannigan
Address 470 Light St.
NOV 18 1945 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 16, 1945, at 2 45 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Skull fracture
Contusion of brain
Due to Intracranial hemorrhage

Other Conditions Fracture of right leg. (Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-14-45 8 45 P. M. 12/4
(b) Where did injury occur? Calvert St. & Mount Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian struck by auto.

23. Signature Benedict Skitarelic M.D. Medical Examiner.
Date signed 11-16-45

Benedict Skitarelic

VS 151

G34234 G34234

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 44B

Registered No.

correct age especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 16 N. Lakewood avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 16 N. Lakewood avenue
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME ANDREW J. STUEHLER, JR.

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Single

6 (b) Name of husband or wife ---
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 19, 1916

8. AGE: Years	Months	Days	If less than one day
28	11	26	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Andrew J. Stuehler
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Frances Dexel
15. Birthplace Baltimore, Maryland

16 (a) Informant Andrew J. Stuehler, Sr.
(b) Address 16 N. Lakewood avenue

17 (a) Burial (b) Date thereof 11/19/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer

18 1945
18 (a) Funeral director Chas. J. Ennis & Son Inc
(b) Address 111 N. Mt. Royal Ave
NOV 8 1945 Huntington Williams, M.D.
(Local registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 15 19 45; at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 19 44 to Nov 15 19 45; and that I last saw him alive on Nov 13 19 45

Immediate cause of death: Ruptured Duodenal Ulcer — Duration 6 days
Due to
Due to
Other Conditions Pyorrhea alveolaris
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Allen J. Lukerasky M.D.
Address 939 N. Eutaw St. Date signed 11/16/45

G34235 — BALTIMORE CITY HEALTH DEPARTMENT — G34235 Registered No.

CERTIFICATE OF DEATH

93D

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2790 The Alameda
(c) Hospital or institution: 9 a.m.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2790 The Alameda (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME: LOUISE C. HODDINOTT

3 (b) If veteran, name war: ****
3 (c) Social Security Account No. ****

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife: Thos. B. Hoddinott
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 3, 1866

8. AGE: Years	Months	Days	If less than one day
79	8	12	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name James Lipp
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Charlotte Davis
15. Birthplace Baltimore, Maryland

16 (a) Informant Thomas Ralph Hoddinott
(b) Address 2790 The Alameda

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 19/45 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director Chas. J. Evans & Son
(b) Address 1525 N. Mt. Royal Ave
(Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 15 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 19 1945 to Nov 15 1945 and that I last saw h[illegible] alive on Nov 15 1945

Immediate cause of death	Duration
Acute Cardiac Dec	2 days.
Due to Hypertension Heart Dis	4 yrs.
Arter. - Sclerosis	
Due to Senile age	
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature L. N. Mezick M.D.
Address 150 E 33rd Date signed 11/17/45

correct age [illegible] especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G34236

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164a

Registered No. G34236

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D. 0. 0
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1526 O'Donnell St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Peter Jaroma

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	married

6 (b) Name of husband or wife (Baron) Katherine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 30-1890

8. AGE: Years	Months	Days	If less than one day
55	5	15	hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Bar. Keeper.

11. Industry or business Own

FATHER
12. Name Paul Jaroma
13. Birthplace Poland

MOTHER
14. Maiden Name Mary ?
15. Birthplace Poland

16 (a) Informant Katherine Jaroma
(b) Address 1526 O'Donnell St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/19/45 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
location Nanticoke Hill Rd.

18 (a) Funeral director John D Connelly
(b) Address 418 Eastern Ave. Cantl 21

19 NOV 17 1945 (Date received by registrar) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 14 1945, at 11 P. M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry and inquiry thereof, and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH asphyxiation

Due to Hanging

Other Conditions Mental Deficiency

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury November 14, 1945 M.
(b) Where did injury occur? In front of 1410 Dillon St
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no
(d) Means of injury Strangling

23. Signature Howard A. Anderson M.D. Medical Examiner.
Date signed 11-15-45

G34237 BALTIMORE CITY HEALTH DEPARTMENT G34237

483595 CERTIFICATE OF DEATH 106 B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Va. (b) County
(c) City or town S. Norfolk.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 110 Park Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Earl S Ginger

3 (b) If veteran, name war

3 (c) Social Security Account No. 225-03-9364

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-4-05

8. AGE: Years	Months	Days	If less than one day
40	6	5/12	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Farm Worker
11. Industry or business

FATHER
12. Name Horace Ginger
13. Birthplace Va

MOTHER
14. Maiden Name Jose. Auston
15. Birthplace Va

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof NOV 19 45 (month) (day) (year)
(c) Cemetery or crematory Glasgow Cem.
Location Glasgow Va.

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 609 Eutaw Place Huntington Williams, M.D.

19 (a) NOV 20 1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov-16 1945 at 7.20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov-13 1945 to Nov-16 1945 and that I last saw him alive on Nov-16 1945

Immediate cause of death	Duration
Cerebral anoxia	
Due to shock	
Due to operation	
Other Conditions bronchiectasis	

(Include pregnancy within 3 months of death)
Date of operation Nov. 14, 1945
Major findings of operation: Ex Tissue bronchiectasis Left lower lobe
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature [illegible] M.D.
Address Johns Hopkins Hosp. Filed 11-17

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G34238

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

G34238 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2519 Madison Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2519 Madison Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie C. Ross

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife none

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1863

8. AGE: Years 82 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name unknown
13. Birthplace unknown

MOTHER
14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant Doris Miller
(b) Address 2519 Madison Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof 11, 19 45
(month) (day) (year)
(c) Cemetery or crematory Orbutus Memorial Park
Location Caroline Co. Md

18 (a) Funeral director Mrs Ida Bailey
(b) Address 1421 Jefferson, St

19 (Date) Huntingtown Williams, Md (Signature of local registrar)

NOV 18 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November, 16 1945 at 1:12 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-6-45 19 to 11-16-45, and that I last saw h alive on 11-16 1945.

Immediate cause of death: Carcinoma of Stomach — Duration 7 mo's

Due to

Due to

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.

Address 2243 Madison Ave Date signed 11/17/45

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34239

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1332 G34239

Please write the causes of death clearly and legibly. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Lafayette
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 8 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Annapolis (If outside city or town limits, write RURAL and give town)
(d) Street No. 103 Prince Georges St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ida L. Freeman

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife William H. Freeman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/4/1880

8. AGE: Years	Months	Days	If less than one day
65	2	14	hr. min.

9. Birthplace Annapolis, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John R. Fouche
13. Birthplace Va.

MOTHER
14. Maiden Name Annie Medford
15. Birthplace Md.

16 (a) Informant Mrs. W. Freeman
(b) Address 103 Prince Georges St Annapolis Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 20 45 (month) (day) (year)
(c) Cemetery or crematory Cedar Bluff Cem
Location Annapolis Md.

18 (a) Funeral director E. Wilbs Lamoreaux
(b) Address 109 W. Baltimore St.

19 (a) Huntington Williams M.D. (Date received by Registrar)

NOV 18 1945
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 18 1945; at 1:30 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/10 1945 to 11/18 1945 and that I last saw h[er] alive on 11/17 1945

Immediate cause of death Heart failure — Duration

Due to Uremia - Bacteria Broken infection — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature David Hall, jr. M.D.
Address Mercy Hosp Date signed 11/18/45

X

G34240

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G34240
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Pennsprings & Belvedere Aves
(c) Hospital or institution: Levendale Hebrew Home & Infirm
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. Belvedere Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Lewis Stock

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years	Months	Days	If less than one day
73			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Not known
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Hosp Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-18-45 (month) (day) (year)
(c) Cemetery or crematory Beth Tefiloh
Location Windsor Mill Rd

18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E. Balto St.

19 (a) (Date received by registrar) (b) Huntington Williams, M.D.

NOV 18 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-17 1945, at 5:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-29 1942 to 11-17 1945 and that I last saw h[illegible] alive on 11-17 1945

Immediate cause of death Generalized arteriosclerosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Edmund Klein

Address Levendale Date signed 11/17/45

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every statement or information should be carefully supplied. The

G34241

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

G34241
Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai 13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2448 Callow Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Moritz Speier

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	wh	M

6 (b) Name of husband or wife Jeanette
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years	Months	Days	If less than one day
70			hr. min.

9. Birthplace Germany
(State, province, country, and state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name Nathan
13. Birthplace Germany

MOTHER
14. Maiden Name Zeitha
15. Birthplace Germany

16 (a) Informant Norbert Speier
(b) Address 2409 Brookfield Ave

17 (a) Burial (b) Date thereof 11-18-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Rosedale
Location Philadelphia Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Baltimore St

19 (a) [illegible] (b) Huntington Williams, M.D.
(Signature of registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-17-45 19..., at 11 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-6-1945 to 11-17-1945 and that I last saw h alive on 11-17-1945.

Immediate cause of death	Duration
Lymphoblastoma exact type undetermined	
Respiratory failure	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Bertha Rader M. D.
Address Sinai Hosp. Date signed 11/17/45

VS 150

G34242

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G34242 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hosp. Balt.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1812 Vienna Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Rent

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1891

8. AGE: Years 54 Months Days If less than one day hr. min.

9. Birthplace Austria
(Town, county, and state)

10. Usual Occupation Grocer

11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Supt. Rennals
(b) Address

17 (a) Burial (b) Date thereof 11-18-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Belair Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E Balt St

19 (a) (Date rec'd by registrar) (b) Huntington Williams Mortuary

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-16-1945, at 8:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-9 1945, to 11-16 1945; and that I last saw h[illegible] alive on 11-16 1945.

	Duration
Immediate cause of death: cardiac failure due to myocardial infarction	2 days
Due to: Pulmonary edema Hydrothorax	?
Due to: CA of liver & spleen arteriosclerotic heart	
Other Conditions: anemia, myocarditis fibrosis (Include pregnancy within 3 months of death)	

Date of operation: none

Major findings of operation: —

of autopsy: the above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Arnall Katz M. D.
Address Sinai Hosp Date signed 11-17-45
Balt. Md

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The cause of death is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G34243

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G34243 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital Monument St.
(c) Hospital or institution: Sinai Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1917 W. North Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HARRY Ely

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Lillian
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1863

8. AGE: Years	Months	Days	If less than one day
82			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Nathan
13. Birthplace Russia

MOTHER
14. Maiden Name Rose
15. Birthplace Russia

16 (a) Informant Jacob Ely
(b) Address Pikesville Road, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-18-45 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location Old Germon Hill Rd.
18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Baltimore St.
19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-16-45 19 , at 4.05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-12 1945, to 11-16 1945, and that I last saw h alive on 11-16-1945.

Immediate cause of death	Duration
Arteriosclerotic Heart disease	
Due to Coronary Sclerosis	
Due to	
Other Conditions Pulmonary edema Diabetes mellitus, peritonitis (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Bertha Kaser M. D.
Address Sinai Hosp Date signed 11/17/45

VS 150

(OVER)

937

Please write plainly, with ink or indelible pencil. Erasures or corrections must be explained. Be sure to state the causes of death clearly and legibly. Exact age is especially important. Physicians: please write the

G34244

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G34244
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 212 Stoney Run Lane
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2047 N. Bentalou St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Irving Joseph Goodman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Dora Goodman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years	Months	Days	If less than one day
53			hr. min.

9. Birthplace New York City
(Town, county, and state)

10. Usual Occupation
11. Industry or business Plumber

FATHER
12. Name Isaac Goodman
13. Birthplace Germany

MOTHER
14. Maiden Name Rose Straules
15. Birthplace New York City

16 (a) Informant Mrs Sylvia Sirkis
(b) Address 2047 N Bentalou St

17 (a) Burial (b) Date thereof Nov, 18, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship Cem
Location 3600 E Baltimore St

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) NOV 18 1945
(Date rec'd by registrar)

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 17 1945, at 2:25PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1943 to Nov 17 1945 and that I last saw h alive on 19

Immediate cause of death Carcinoma of Bowel about

Duration 2 years

Due to

Due to

Other Conditions Metastasis to Liver & Bladder
(Include pregnancy within 3 months of death)

Date of operation Dec. 11, 43.

Major findings of operation: Inoperable Carcinoma

of autopsy: of Bowel

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Theodore N. Morrison M. D.
Address 11 E. Eutaw St Date signed 11/17/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34245

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G34245 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6 E Reed St
(c) Hospital or institution:
11
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 9 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6 E Reed St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George W. Carter Jr

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 217-09-2867

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6 - 1890

8. AGE: Years	Months	Days	If less than one day
55	6	10	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Painter

11. Industry or business Self.

FATHER
12. Name George W. Carter Sr.
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Clara Ford.
15. Birthplace Baltimore Md

16 (a) Informant Mrs Dorothea
(b) Address 4921 Oakford Ave.

17 (a) Burial (b) Date thereof Nov 19-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location

18 (a) Funeral director Chas S Powell
(b) Address 2427 Edmondson Ave.

19 (a) NOV 18 1945 (b) Huntington Williams M.D.
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 16 - 1945, at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/4 1945 to 11/13 1945, and that I last saw him alive on 10/26 1945

Immediate cause of death Cerebral Thrombosis

Due to

Due to Uremia: Cystitis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Cystitis Prostatic Hypertrophy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature Chas S Powell
Address 2427 Edmondson Ave Date signed 11/19/45

VS 150

Do not write in this space. Physicians: please write the causes of death clearly and legibly. Exact age is especially important.

G34246

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G34246
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai Hospt 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1721 N. Appelton St
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Tucker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-17-45

8. AGE: Years | Months | Days 1 | If less than one day ..... hr. ..... min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Nathan Tucker
13. Birthplace Balto Md

MOTHER
14. Maiden Name Emma
15. Birthplace Balto Md

16 (a) Informant Hospt Records
(b) Address

17 (a) Burial (b) Date thereof 11-18-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Herring Run
Location Pulaski Hy & Bowley Lane

18 (a) Funeral director Funk Lenz Inc
(b) Address 1439 E. Balto St

19 (a) (b) Hunting[illegible] Williams, M.D.

NOV 18 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH November 18, 1945 at 8:25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 17, 1945 to Nov. 18, 1945 and that I last saw him alive on Nov. 18, 1945

Immediate cause of death Cardiac failure — Duration
Due to Aspiration pneumonia ? —
Due to —
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert J. Means M. D.
Address Sinai Hospital Date signed 11/18/45

VS 150

PRINT WITH PENCIL, WITH UNFADING INK. Every item of information should be carefully supplied. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

367924
G34247

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

52 B

Registered No. G34247

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State NY (b) County.....
(c) City or town New York (If outside city or town limits, write RURAL and give town)
(d) Street No. 3 King St. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Clement Bernstein

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	W

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-2-83

8. AGE: Years	Months	Days	If less than one day
61	11		hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business

FATHER
12. Name Issac Bernstein
13. Birthplace Russia

MOTHER
14. Maiden Name Helen Rauanitz
15. Birthplace Russia

16 (a) Informant.....
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal - (b) Date thereof 11 1845
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Beth David
Location Long Island, New York

18 (a) Funeral director Philip Ferris & Sons
(b) Address 2024 Orleans St

19 (a)..... (b).....
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 18- 1945 at 3 50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-8- 1945 to 11-18- 1945
and that I last saw h[illegible] alive on 11-18- 1946

Immediate cause of death Pulmonary Embolus — Duration .....

Due to Post-operative — 7d.

Due to..... — over

Other Conditions Bladder tumor

(Include pregnancy within 3 months of death)
Date of operation 11/12/45
Major findings of operation: 2 papilla bladder tumors
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....

23. Signature Herbert Brenda M.D.
Address Johns Hopkins Hosp. Date signed 11/18/45

VS 150

correct age is especially important. Physicians: please write the

G34248 383 757

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1248

G34248 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 Wks
(e) Length of stay in Baltimore (yrs., mos., or days) 6 Wks

2. USUAL RESIDENCE OF DECEASED:
(a) State Texas (b) County
(c) City or town San Antonio
(If outside city or town limits, write RURAL and give town)
(d) Street No. 127 Ridgewood Pl
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Oliver Flato

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	Divorced

6 (b) Name of husband or wife Jane Church
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-14-02

8. AGE: Years	Months	Days	If less than one day
43	5	4	hr. min.

9. Birthplace Texas (Town, county, and state)
10. Usual Occupation Pres. American Furniture Co
11. Industry or business Manufacturer

FATHER
12. Name Henry Flato
13. Birthplace Texas

MOTHER
14. Maiden Name Minnie Oliver
15. Birthplace Kansas

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Nov. 16 1945 (month) (day) (year)
(c) Cemetery or crematory Mission Cemetery
Location San Antonio Texas
18 (a) Funeral director William J. Tickner & Sons
(b) Address North & Pennsylvania Aves.
19 (a) 11-16-45 (Date rec'd by registrar) (b) Huntington Mitchell, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 18 1945 at 4 05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-1- 1945 to 11-18- 1945
and that I last saw h alive on 11-18- 1945
Immediate cause of death RESPIRATORY FAILURE AND CARDIAC FAILURE — Duration 4 MOS.
Due to PULMONARY CONGESTION from RHEUMATIC HT DISEASE
Due to CIRRHOSIS OF LIVER AND EXHAUSTION
Other Conditions Cirrhosis of liver, thrombophlebitis, cystitis
(Include pregnancy within 3 months of death)
Date of operation 10-22-45
Major findings of operation: CIRRHOSIS OF LIVER
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Joseph M. Young M. D.
Address Johns Hopkins Hosp Date signed 11-18-45

VS 150

Nat. 367939
G34249

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G34249 Registered No. 90B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2025 Kennedy ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William ? Parmer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married.

6 (b) Name of husband or wife Sylvia Parmer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-16-94.

8. AGE: Years	Months	Days	If less than one day
50	11	2	hr. min.

9. Birthplace Pa.
(Town, county, and state)
10. Usual Occupation Machinist
11. Industry or business Washington Navy Yard

FATHER
12. Name William James Parmer
13. Birthplace Pa.

MOTHER
14. Maiden Name Lillian Hoopes
15. Birthplace Pa.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 11/21/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Rancks
Location New Holland Pa.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul st.

19 (a) NOV 19 1945 Washington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-18 1945 at 2 28 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-9 1945 to 11-18 1945 and that I last saw h... alive on 11-18 1945

Immediate cause of death ? Constrictive pericarditis

	Duration
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jas. Wilson M. D.
Address Johns Hopkins Hosp Date signed 11/18/45

VS 150

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34250

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G34250
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 401 Haw Thorne Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Anita K. Loren

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) ~~Single, married~~, widowed, or ~~divorced~~ Widowed

6 (b) Name of husband ~~or wife~~ Irving Loren

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 18th 1893

8. AGE: Years 52 | Months 3 | Days 29 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation housewife + Clerk

11. Industry or business Read Drug Co

FATHER
12. Name William C. Kaufman
13. Birthplace Md

MOTHER
14. Maiden Name Anna C. Kehne
15. Birthplace Md.

16 (a) Informant Nancy B. Kaufman
(b) Address 263 Dumbarton Rd Govans

17 (a) Cremation (b) Date thereof 11/19/45
(Burial, cremation, or removal) (month) (day) (year)
(c) ~~Cemetery or~~ crematory Green Mount
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) (b)
(Date received by registrar) Registrar

NOV 19 1945

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 17 1945, at 4:18 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-11 1945, to 11-17 1945, and that I last saw h~~e~~r alive on 11-17 1945.

Immediate cause of death Peritonitis + toxemia + atelectasis — Duration 9 days

Due to perforated Sigmoid

Due to Carcinoma of Sigmoid — 1 Wk.

Other Conditions Hydrothorax abdom. abscess, fecal fistula

(Include pregnancy within 3 months of death)

Date of operation 11-12-45

Major findings of operation: peritonitis

of autopsy: no about

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Osmund Wiesner M. D.

Address Univ. Hosp. Date signed 11-17-45

VS 150

X

G34251

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G34251

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address North Broadway
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 59 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore, Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4228 Sheldon Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MAUDE ANNA STREIB

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: John C Streib
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Sept 29 1886

8. AGE: Years 59 | Months 1 | Days 18 | If less than one day ____ hr. ____ min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: housework

11. Industry or business

FATHER
12. Name: Edward Brown
13. Birthplace: New York

MOTHER
14. Maiden Name: Nettie Trauper
15. Birthplace: New York

16 (a) Informant: John C. Streib
(b) Address: 4228 Sheldon Ave-13

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-19-45 (month) (day) (year)
(c) Cemetery or crematory: Baltimore Cem.
Location: Baltimore Md

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 (a) Received by registrar NOV 19 1945 Huntington Williamsville, Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 16th 1945; at 11:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 15 1945 to Nov 16 1945, and that I last saw her alive on Nov 16 1945

Immediate cause of death	Duration
Pulmonary edema	
Due to congestive heart failure	
Due to Hypertensive Cardiovascular disease	
Other Conditions aneurysm at bifurcation of aorta	

(Include pregnancy within 3 months of death)

Date of operation 11/15/45

Major findings of operation: aorta Aneurysm at bifurcation of

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Phyllis R Ingram M. D.
Address Church Home & Hosp Date signed 11/19/45

X Ingram

G34252 ✓ G34252

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1325 Wilcox Street
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) ## 41 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1325 Wilcox Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Thomas William Lauder

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Elizabeth Slater
6 (c) If alive, give age: 64 years

7. Birth date of deceased (mo., day, yr.): July 17, 1883

8. AGE: Years: 62 | Months: 3 | Days: 29 | If less than one day: ######## hr. ____ min.

9. Birthplace: England
(Town, county, and state)
10. Usual Occupation: Retired Bricklayer
11. Industry or business

FATHER
12. Name: George Lauder
13. Birthplace: England

MOTHER
14. Maiden Name: Mary Briggs
15. Birthplace: England

16 (a) Informant: Mrs. Elizabeth Lauder
(b) Address: 1325 Wilcox Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/20/45 (month) (day) (year)
(c) Cemetery or crematory: Morlands Memorial Pk.
Location: Taylor Ave., Balto Co.

18 (a) Funeral director: George J. Ruth, Inc.
(b) Address: 1735 Harford Avenue

19 (a) NOV 19 1945 (Date received) Huntington Williams, M.D.

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 16 1945 at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/9 1945 to 11/16 1945, and that I last saw h[illegible] alive on 11/16/1945.

Immediate cause of death: Intermediate Cardio-Vascular Renal Disease — Duration: ?

Due to:

Due to:

Other Conditions: Prostatic Hypertrophy — Duration: ?
Uremia
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: Joseph L. Blum M.D.
Address: 206 E. Preston St. Date signed 11/17/45

X

G34253

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

47

Registered No. G34253

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert + Saratoga Sts.
(c) Hospital or institution:
Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 8 Days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Howard
(c) City or town Ellicott City
(If outside city or town limits, write RURAL and give town)
(d) Street No. Main St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin Franklin Sisk

3 (b) If veteran, name war: World War I

3 (c) Social Security Account No. 213-05-9562

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: M.

6 (b) Name of husband or wife: Mary Jane Sisk

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 29 1898

8. AGE: Years 47 | Months 6 | Days 21 | If less than one day hr. min. 20

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Silas Sisk
13. Birthplace Virginia

MOTHER
14. Maiden Name Sarah Phelps
15. Birthplace Maryland

16 (a) Informant Mary Janet Sisk
(b) Address Ellicott City Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-21-1945 (month) (day) (year)
(c) Cemetery or crematory Good Shepherd
Location Ellicott City Md.

18 (a) Funeral director J. C. Hyndman Sons
(b) Address Ellicott City Md.

NOV 19 1945 (Date rec'd by Registrar) (Huntington Williams M.D.)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/19 1945 at 1:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h.i.m alive on 11/18 19 45

Immediate cause of death: Cardio Respiratory Failure

Due to: Heart block

Due to: Cancer Left Lung

Other Conditions: Cachexia

(Include pregnancy within 3 months of death)
Date of operation 11/17/45

Major findings of operation: Gastrostomy performed

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. K. Brendle M. D.
Address Mercy Hosp. Date signed 11/19/45

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34254

BALTIMORE CITY HEALTH DEPARTMENT ✓ G34254
CERTIFICATE OF DEATH 46E
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 314 Penn ST
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 314 Penn St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Brazauskas

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. 212-18-2114

4. Sex Male | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife MIKALINA

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1867

8. AGE: Years 78 | Months | Days | If less than one day hr. min.

9. Birthplace Lith
(Town, county, and state)

10. Usual Occupation Sailor

11. Industry or business

FATHER
12. Name ?
13. Birthplace Lith

MOTHER
14. Maiden Name ?
15. Birthplace Lith

16 (a) Informant Frank Brazas
(b) Address 314 Penn St

17 (a) Burial (b) Date thereof Nov. 20-46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Belair Rd

18 (a) Funeral director Joseph Kaminskas
(b) Address 602 W Lake Blvd

19 (a) (b)
(Date received by Registrar) (Signature of Registrar)
NOV 19 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 17 1945, at 2:18 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from August 19 45 to Nov 17 1945, and that I last saw h. alive on Nov 17 1945.

Immediate cause of death	Duration
Carcinoma of stomach	1 yr
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. S. Pemple MD.
M. D.
Address 642 Wash Blvd Date signed 11-17-45.

Hunting for Next of Kin

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34255

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G34255

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 102 W. 39th St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 112 W. 39th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZABETH McL. HARPER

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	widow

6 (b) Name of husband or wife Andrew J. Harper
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 3, 1873

8. AGE: Years	Months	Days	If less than one day
72	10	13	hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Daniel McLaughlin
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Mary E. Rouse
15. Birthplace Balto., Md.

16 (a) Informant Mr. Alan J. Harper
(b) Address 102 W. 39th St.

17 (a) Burial (b) Date thereof 11/19/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (b) Hunting for Williams
(Date rec'd by registrar) Registrar

NOV 19 1945

VS 10

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 16, 1945, at 11 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 14, 1945 to Nov. 16 1945, and that I last saw h[illegible] alive on Nov. 16, 1945.

Immediate cause of death	Duration
Cerebral hemorrhage	6 days.
Due to Arteriosclerosis	2
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
Means of injury

23. Signature Eugene L. Cassano M. D.
Address 514 Dorsey Lane Date signed 11/17/45

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

G34256

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

G34256

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address CATON & WILKENS AVE
(c) Hospital or institution:
ST. AGNES HOSP.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 1 0
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Little Sisters of the Poor
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MRS. EVA KYTRYH (Kudrash)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1868

8. AGE: Years 77 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace RUSSIA
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name THEODORE
13. Birthplace RUSSIA

MOTHER
14. Maiden Name CHRISTINE
15. Birthplace RUSSIA

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley St

17 (a) Burial (b) Date thereof Nov. 20, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Windefeld
(b) Address 914 Greenmount Ave

19 (a) (Date rec'd by registrar) NOV 19 1945 (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 | 18 1945 at 6.55 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11 | 9 1945 to 11 | 18 1945.
and that I last saw her ALIVE on 11 | 18 1945.

Immediate cause of death	Duration
TERMINAL PNEUMONIA.	
Due to	
Due to GEN. ARTERIOSCLEROSIS	
GANGRENE LT. LOWER EXTREM	
Other Conditions SENILITY	
MALNUTRITION	

(Include pregnancy within 3 months of death)

Date of operation 11/17/45

Major findings of operation: GANGRENE LT. LOWER EXTREM.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. Norton Stretz M.D.
Address St. Agnes Date signed 11/19/45

READ WITH PENCIL, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34257

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. G34257

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4225 Belmar Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 W
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4225 Belmar Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Mary C. Welsh

3 (b) If veteran, name war (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Wm. F. Welsh
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 1, 1874

8. AGE: Years	Months	Days	If less than one day
71	10	15	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Peter Crawley
13. Birthplace Ireland

MOTHER 14. Maiden Name Mary Hughes
15. Birthplace Baltimore

16 (a) Informant Mary Welsh
(b) Address 4225 Belmar Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 20, 1945 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Peter Wiedefeld
(b) Address 914 Greenmount Ave

19 (a) NOV 19 1945 (Date received by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/16 1945; at 5-30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/15 1945 to 11/16 1945 and that I last saw h[illegible] alive on 11/15/1945.

Immediate cause of death	Duration
CEREBRAL THROMBOSIS	2 DAYS
Due to ARTERIO SCLEROSIS	10 YRS.+
ARTERIAL HYPERTENSION	10 YRS+
Due to	
Other Conditions DIABETES MELLITUS	3 MOS.
SENILITY	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John W Mackey M. D.
Address 6 E. Lexington St. Date signed 11/17/45

VS 150

Dr. Mudaline Belair Road 6304 83B

G34258

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G34258

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 723 Belgian Ave
(c) Hospital or institution: At Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 723 Belgian Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marjorie M. Sivris

3 (b) If veteran, name war: No

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: William M. Sivris

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 5 1897

8. AGE: Years 48 | Months 8 | Days 12 | If less than one day hr. min.

9. Birthplace Mt Washington Balto Md (Town, county, and state)

10. Usual Occupation Home work at

11. Industry or business Home

FATHER
12. Name Patrick W. Scott
13. Birthplace Mt Washington Md.

MOTHER
14. Maiden Name M. Elizabeth Hoffman
15. Birthplace Mt Washington Md

16 (a) Informant Mrs. Wm M. Sivris
(b) Address 723 Belgain Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 20/45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md.

18 (a) Funeral director Elmer W. Coughlin Son
(b) Address 924 E. Eager St.

19 (a) (Date received by local registrar) NOV 19 1945 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 17, 1945, at 3:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 2 1937 to Nov. 17 1945 and that I last saw h[illegible] alive on Nov. 14 1945.

Immediate cause of death: Acute Cardiac Failure — Duration 10 minutes
Due to: Hypertensive Cardio-Vascular Renal Disease — Duration 2 yrs.
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Israel Rosen M.D. M. D.
Address 2413 E Monument St Date signed X 11/19/45

Instructions: Fill in all items, if unknown, write UNKNOWN. Every item must be answered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34259

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G34259
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1007 N. Carrollton Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1007 N. Carrollton Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Milton Snowden

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1899

8. AGE: Years	Months	Days	If less than one day
46			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 21 1945 (month) (day) (year)

(c) Cemetery or crematory Woodlawn

Location Catonsville Maryland

18 (a) Funeral director Roy W Barbee

(b) Address Laytonsville Md

19 (a) 19 1945 (To be filled in by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/18 1945, at 10:45 AM

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bronchopneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Dr. J. Lubinski M.D.
Medical Examiner.

Date signed 11/18/45

VS 151

534260

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Register's No. 534260

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Ave
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in Hospital or inst. (yrs., mos., or days) 7 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 7 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. St. Agnes Hospital
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Sister Teresa Ferriter

3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ✓

4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced. single
6 (b) Name of husband or wife ✓
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 3/8/1870
8. AGE: Years 75 Months 8 Days 9 If less than one day hr. min.
9. Birthplace Tarrandra Pa (Town, county, and state)
10. Usual Occupation Sister of Charity
11. Industry or business

FATHER
12. Name Nicholas Ferriter
13. Birthplace County Kerry, Ireland

MOTHER
14. Maiden Name Mary Sullivan
15. Birthplace County Kerry, Ireland

16 (a) Informant St. Agnes Hospital
(b) Address Caton & Wilkens Ave

17 (a) Burial (b) Date thereof 11/20/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Martin Bagley & Sons
(b) Address 1827 W. North Ave.

NOV 19 1945 Huntington Williams, MD
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/17 1945, at 6:45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1945 to Nov 17 1945, and that I last saw h[illegible] alive on Nov 17 1945.

Immediate cause of death	Duration
Uremia Coma	
Due to Renal transplantation & generalized arteriosclerosis	
Due to	
Other Conditions Diabetes mellitus arteriosclerotic cardio vascular disease	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Chas Ratrick, M.D.
Address St. Agnes Hosp Date signed 11/18/45

VS 180

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PRESS WHITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34261

BALTIMORE CITY HEALTH DEPARTMENT X ✓ 109a

CERTIFICATE OF DEATH

Registered No. G34261

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green St.
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Chase Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. Eastern Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Louis Beasley Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife Margaret
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4, 1916

8. AGE: Years	Months	Days	If less than one day
29	4	11	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Janitor
11. Industry or business

FATHER
12. Name Louis Beasley
13. Birthplace Bells Md

MOTHER
14. Maiden Name Lela McClurings
15. Birthplace Bells Md

16 (a) Informant Margaret Beasley
(b) Address Benfield Md

17 (a) Burial (b) Date thereof Nov 18/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sharp St. Cemetery
Location Chase Md

18 (a) Funeral director Mrs. Robert A. Elliott & Son
(b) Address 1129 N. Fremont St

19 (a) (b) Huntington Williams, M.D.
(Registrar) Registrar

NOV 19 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/15/45 19 , at 9:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 8 1945 to Nov 15 1945 and that I last saw h.. M alive on Nov 15 1945

Immediate cause of death anoxia

Due to pneumonia, atypical

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James P. McHugh Jr. M.D.
M. D.
Address Towson Md Date signed 11/16/45

McHenry

G34262

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

G34262 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1510 W. Lanvale St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 52 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1510 W. Lanvale St.
(If rural give location)
(e) If foreign born, how long in U. S. A.? — years

3 (a) FULL NAME Lela Annetta Jackson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex female | 5. Color or race colored | 6 (a) Single, married, widowed, or divorced. Divorced

6 (b) Name of husband or wife Walter Smith

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) November 1, 1890

8. AGE: Years 55 | Months — | Days 14 | If less than one day — hr. — min.

9. Birthplace Denton, Maryland
(Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER
12. Name Robert Henry Jackson
13. Birthplace Essex County, Va.

MOTHER
14. Maiden Name Mary Alice Thomas
15. Birthplace Denton, Md.

16 (a) Informant Mrs. Sadie B. Scott
(b) Address 918 Russell St. - Balto.

17 (a) Burial (b) Date thereof Nov. 19 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Pk.
Location Baltimore Co. Md

18 (a) Funeral director Wm. Geo. H. Stallings
(b) Address 1631 Druid Hill Ave

NOV 19 1945 Huntington Williams M.D.
(Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11.14.45 19..., at 11:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12.2.44 19..., to 11.14.45 19..., and that I last saw her alive on 11.14.45 19....

Immediate cause of death	Duration
Hemorrhage	11.13.45
Due to Carcinoma right inguinal gland.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence —
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature James M. Pair M. D.
Address 400 N. Carrollton Date signed 11.14.45

VS 3

James M. Pair

1263

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83B ✓ Registered No. G34 66035

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital, Baltimore, Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1118 Williams St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Oscar Hostine McCauley

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife Theodocia McCauley
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) November 9, 1875

8. AGE: Years	Months	Days	If less than one day
70	0	9	hr. min.

9. Birthplace Bedford, Maryland (Town, county, and state)
10. Usual Occupation Engineer
11. Industry or business Seafarer

FATHER
12. Name Daniel McCauley
13. Birthplace Cecil Co., Maryland

MOTHER
14. Maiden Name Catherine Funk
15. Birthplace Frederick, Maryland

16 (a) Informant Records
(b) Address U. S. Marine Hospital, Balto., Md.

17 (a) Burial (b) Date thereof Nov 21-45 (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory Loudon Park
Location Frederick Road

18 (a) Funeral director Williams Bros. Inc.
(b) Address 1417 Park Ave.

NOV 19 1945 (Date rec'd by registrar) Herrington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 18 1945, at 2:30AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/14 1945 to 11/18 1945, and that I last saw him alive on 11/18 1945.

Immediate cause of death	Duration
Cerebral Thrombosis	2 weeks
Due to	
Due to	
Other Conditions Arteriosolerosis, generalized. (Include pregnancy within 3 months of death)	unknown

Date of operation
Major findings of operation:
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address Clinical Director Date signed Nov. 19, 45
U. S. Marine Hospital, Balto., Md.

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G34264

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. G34264

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5514 Fernpark Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days) 18 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md/ (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5514 Fernpark Avenue
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Clara Adelia Crownhart

3 (b) If veteran, name war ###

3 (c) Social Security Account No. ###

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Winfield S.
6 (c) If alive, give age ## years

7. Birth date of deceased (mo., day, yr.) Nov. 5, 1855

8. AGE: Years 90 | Months 0 | Days 13 | If less than one day ____ hr. ____ min.

9. Birthplace Bridgeport, N.Y.
(Town, county, and state)

10. Usual Occupation
11. Industry or business Housewife

FATHER
12. Name George Terpenny
13. Birthplace New York State

MOTHER
14. Maiden Name Hanna Emmons
15. Birthplace New York State

16 (a) Informant Floyd A. Crownhart
(b) Address 3136 Northway Dr. Balto.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 20, 45 (month) (day) (year)
(c) Cemetery or crematory Still Pond
Location Still Pond, Kent Co., Md.

18 (a) Funeral director Walter Brooks Bradley
(b) Address 1922 N. North Avenue

19 NOV 19 1945 (Date received by local registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 18 1945, at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 12 1945, to Nov 18 1945, and that I last saw h. alive on Nov 17 1945

Immediate cause of death Pneumonia & Labor — Duration 5 days

Due to

Due to

Other Conditions arteriosclerosis Myocarditis about 3 mo. 7
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter L Niblett M. D.
Address 2220 Harrison Blvd. Date signed Nov 19/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

634265

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1108

Registered No. 634265

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Provident Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1506 Whitelock Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Chester H. Jackson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Grace Jackson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 18- 1912

8. AGE: Years: 33 | Months: 6 | Days: 29 | If less than one day: hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Chauffeur

11. Industry or business

FATHER
12. Name Wm. Jackson
13. Birthplace Va.

MOTHER
14. Maiden Name Bettie Washington
15. Birthplace Va.

16 (a) Informant Grace Jackson
(b) Address 1506 Whitelock St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/20/45 (month) (day) (year)
(c) Cemetery or crematory Glouster Co. Va.
Location Glouster Co. Va.

18 (a) Funeral director Geo. H. Kelson
(b) Address 1303 Pressman St

NOV 19 1945 (b) Registrar Huntington Williams, M.D.
(Date received by Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 17, 1945 at 2:30 P. M.

21. I certify that I took charge of the remains described above, held an Inspection + Inquiry Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pneumonia, lobar

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skotarelis M.D.
Medical Examiner.
Date signed November 18, 1945.

G34266

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

G34266 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2914 St. Paul street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ---
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2914 St. Paul street
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME LORETTO C. KAHLER

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	Divorced

6 (b) Name of husband or wife -----
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 29, 1883

8. AGE: Years	Months	Days	If less than one day
62	6	17	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business

FATHER
12. Name Joseph Crane
13. Birthplace Germany

MOTHER
14. Maiden Name Caroline Bamberger
15. Birthplace Baltimore, Maryland

16 (a) Informant Francis Crane Kahler
(b) Address 2914 St. Paul street

17 (a) Burial (b) Date thereof Nov. 20/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director Thos. J. Evans & Son Inc.
(b) Address 5 W. Mt. Royal Ave

NOV 19 1945 (a) (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 16 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1945, to Nov 16 1945, and that I last saw her alive on Nov 16 1945.

Immediate cause of death	Duration
Coronary Thrombosis	Unknown
Due to Arteriosclerosis	Unknown
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thos. J. Evans & Son Inc. M.D.
Address 2923 St Paul St Date signed 11/18/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34267

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

G34267 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5d.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1206 Myrtle Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ronnie Branch

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	M.

6 (b) Name of husband or wife Viola
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years	Months	Days	If less than one day
63			hr. min.

9. Birthplace North Carolina (Town, county, and state)
10. Usual Occupation Waiter
11. Industry or business

FATHER
12. Name Mike Branch
13. Birthplace North Carolina

MOTHER
14. Maiden Name Alice Garrison
15. Birthplace North Carolina

16 (a) Informant Viola Branch
(b) Address 1206 Myrtle Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-21-45 (month) (day) (year)
(c) Cemetery or crematory Arbutus Park
Location Baltimore
Funeral director Wm Francis A Hemsley
Address 578 W Biddle St

(Date received by local registrar) NOV 19 1945 (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/16 1945 at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/11 1945, to 11/16 1945, and that I last saw h[illegible] alive on 11/16 1945.

Immediate cause of death Cerebral Embolism

Duration

Due to Auricular Fibrillation

Due to Chronic Myocarditis

Other Conditions Hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chas Gluckman M.D.
Address Mercy Hosp Date signed 11/16/45

150

G34268

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G34268 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Harford Road & Herring Run
(c) Hospital or institution: Lyden Ham Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6104 Fairmount Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNIE ELEY

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Widowed

6 (b) Name of husband or wife Riddick Eley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-25-1891

8. AGE: Years	Months	Days	If less than one day
53	10	17	hr. min.

9. Birthplace Suffolk Va.
(Town, county, and state)
10. Usual Occupation Maid
11. Industry or business

FATHER
12. Name John Porter
13. Birthplace Va.

MOTHER
14. Maiden Name Mary
15. Birthplace Va.

16 (a) Informant Hospital records
(b) Address Lydenham Hosp.

17 (a) Burial (b) Date thereof Nov. 19, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Pk
Location Baltimore, County
18 (a) Funeral director Charles G. Cooper
(b) Address 512 N. Carrollton Ave
19 (a) (b)
(Date rec'd by Registrar) Registrar

NOV 19 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 11 1945, at 1.35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 9 1945 to Nov 11 1945
and that I last saw h.er alive on Nov 11 1945

Immediate cause of death	Duration
Probable Cerebral accident	
Due to Hemorrhage	
Due to Hypertensive cardio	
Other Conditions Vascular disease Pneumonia (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Margaret H. O. Smith M. D.
Address Lydenham Hosp Date signed 11-11-45

Huntington Hollins

G34269 BALTIMORE CITY HEALTH DEPARTMENT G34269

CERTIFICATE OF DEATH 119a

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age as specifically important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 600 S. Eutaw St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 600 S. Eutaw Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Josephine Edwards G.34695

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/1/1945

8. AGE: Years	Months	Days	If less than one day
	2	14	hr. min.

9. Birthplace Baltimore City
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Joseph Edwards
13. Birthplace Md.

MOTHER
14. Maiden Name Rosie Mitchell
15. Birthplace Md.

16 (a) Informant Rosie Edwards
(b) Address 600 S. Eutaw St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-19-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location A. A. Co., Md.

18 (a) Funeral director Robert E. Williams
(b) Address 1515 McElderry St.

19 (a) Nov 19 1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 16, 1945, at 10 AM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Infantile diarrhea

Due to

Other Conditions 1
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Foster M.D.
Medical Examiner.
Date signed Nov. 17 1945

G34270

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G34270 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Randall St.
(b) Street address 130 E. [redacted] St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 54
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 130 E. Randall St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice V. Carneal

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	M.

6 (b) Name of husband or wife Leonard
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 19, 1892

8. AGE: Years	Months	Days	If less than one day
53	4	28	hr. min.

9. Birthplace Balto.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Howard Undel
13. Birthplace Balto.

MOTHER
14. Maiden Name Minnis
15. Birthplace Va.

16 (a) Informant Family
(b) Address 130 E. Randall St.

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 11-20-45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd.

18 (a) Funeral director James L. McCauley
(b) Address 30 S. Paca St.

19 (a) (Date received by registrar) (b) NOV 19 1945 Registrar Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 17 1945, at 10A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 10 1945, to Nov 17 1945, and that I last saw h[illegible] alive on Nov 17 1945

Immediate cause of death	Duration
Embolism	2 days
Due to: Cerebral Hemorrhage	7 days
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. E. K. Campbell M.D.
Address 1644 Hanover Date signed 11/19/45

X

Please write plainly, with pen and ink. Physicians: please write the causes of death clearly and legibly. Information should be carefully supplied. The correct age is especially important.

G34271

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 479

Registered No. G34271

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 28 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1104 Pratt Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Steve Bichanich

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Mary (D)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 16-1892

8. AGE: Years 53 | Months 3 | Days 0 | If less than one day ... hr. ... min.

9. Birthplace Yugoslavia
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Michael Bichanich
13. Birthplace Yugoslavia

MOTHER
14. Maiden Name Agnes Douglas
15. Birthplace Yugoslavia

16 (a) Informant Records-Balto. City Hospitlas
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/20/45 (month) (day) (year)
(c) Cemetery or crematory Holy Trinity Russian
Location Fort Meade Rd. A.G. Co.

18 (a) Funeral director Lilly & Zeiler Dy.
(b) Address 402 S. Schmidt St.

19 (a) 1945 by registrant (b) Huntington Williams, M.D. Registrar

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 16 1945, at 1:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 11 1945, to Nov. 16 1945, and that I last saw h. im alive on Nov. 16 1945.

Immediate cause of death: Carcinoma & metastases
Due to: primary probably in lung.

Duration: ?

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Margaret M. Dowes M. D.
Address 4940 Eastern Ave. Date signed 11-19-45

G34272

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

437

G34272 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2029 N Wolfe
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town 2029 N Wolfe
(If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth McConnell

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife Owen McConnell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 26 1874

8. AGE: Years	Months	Days	If less than one day
71	-	22	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation
11. Industry or business At Home

FATHER
12. Name Christian L Frese
13. Birthplace Germany

MOTHER
14. Maiden Name Philippine Koch
15. Birthplace Germany

16 (a) Informant Owen McConnell
(b) Address 2029 N Wolfe St

17 (a) Burial (b) Date thereof Nov 20
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mount Carmel
Location Catonsville

18 (a) Funeral director Merritt Funeral Home
(b) Address 2008 Orleans

19 (a) (b) Huntington Williams, M.D.
Registrar

NOV 13 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 17th 1945 at 11:25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 9 1945 to Nov 17 1945 and that I last saw h alive on Nov 13 1945.

Immediate cause of death	Duration
Cardio Vascular Hypertension	3 yrs.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dr. S. H. Barranco M. D.
Address 436 E Fort Ave Date signed 11/13/45

correct age is especially important. Physicians: please write the

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G34273 / 61 / G34273

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2844 Harford Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 43 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2844 Harford Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Daisy May Shawen

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Howard C. Shawen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 9 1879

8. AGE: Years 66 | Months 6 | Days 8 | If less than one day ... hr. ... min.

9. Birthplace Washington Co Md (Town, county, and state)

10. Usual Occupation
11. Industry or business At home

FATHER
12. Name Colman Haines
13. Birthplace Md

MOTHER
14. Maiden Name Fannie Phillips
15. Birthplace Md

16 (a) Informant Mrs Paul E Jones
(b) Address 2844 Harford Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 20th (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location City

18 (a) Funeral director Wellsich Funeral Home
(b) Address 2008 Orleans

19 (a) ... (Date rec'd by registrar) (b) NOV 19 1945 Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 17 1945, at 4:31 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-18- 1937, to 11-17- 1945; and that I last saw her alive on 11-16- 1945.

Immediate cause of death	Duration
Arteriosclerotic cardio-renal disease	ten years
Due to Diabetes mellitus	ten years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Geo B. Sybert M. D.
Address 2800 Harford Rd Date signed 11-17-45

X

VS 150

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRINTED WITH FADING, WITH UNFADING INK.

G34274

BALTIMORE CITY HEALTH DEPARTMENT G34274

CERTIFICATE OF DEATH 137a Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Joseph's Hospital. 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3041 Grayson St. (If rural give location)
(e) Citizen of foreign country? ditto (Yes or No)
If yes, name country

3 (a) FULL NAME Valentine H. Dwyer (or Dwyer.)

3 (b) If veteran, name war: W.W.I

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Gertrude E.

(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-4-1889

8. AGE: Years 56 | Months 5 | Days 17 | If less than one day: hr. min.

9. Birthplace: Baltimore.
(Town, county, and state)

10. Usual Occupation: Dispatcher

11. Industry or business: Balto Transit Co.

FATHER
12. Name: George Joseph Dwyer
13. Birthplace: Md

MOTHER
14. Maiden Name: Pauline Eberhardt.
15. Birthplace: Germany

16 (a) Informant: Mrs. Gertrude E. Dwyer
(b) Address: 3041 Grayson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-20-45 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Baltimore, Md

18 (a) Funeral director: G. Howard Strong
(b) Address: 3707 W. North Ave.

19 (a) [illegible] (b) Date received by registrar: Nov 19 1945 Washington Hollinwood, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-16 1945, at 12:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-10 1945 to 11-16 1945, and that I last saw h[illegible] alive on 11-16 1945

Immediate cause of death: Cardio-respiratory failure — Duration

Due to: Cerebral hemorrhage

Due to: Brain abscess.

Other Conditions: Prostatic hypertrophy & prostatic abscess.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Brain abscess & Prostatic abscess.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Eugene F. Riley M.D.

Address: 1400 N. Caroline Date signed 11/16/45

X Riley

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The certificate when completed, will be UNFADING INK.

VS 150

HEALTH DEPARTMENT—CITY OF BALTIMORE

G34275

CERTIFICATE OF DEATH

√161a G34275

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 963 Washington St., 4 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. ds. If not in U. S. long If of foreign birth? yrs. mos. ds.

2. FULL NAME Clarence Ranson Jr.

If U. S. Veteran specify WAR

(a) Residence: No. 963 Washington St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Male	Col	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6. DATE OF BIRTH (month, day, year) 11/8/45

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
		9	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Child

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Baltimore Md.

FATHER

13. NAME Clarence Ranson

14. BIRTHPLACE (city or town) (State or country) Va

MOTHER

15. MAIDEN NAME Lottie Jordon

16. BIRTHPLACE (city or town) (State or country) N. C.

17. INFORMANT Clarence Ranson Sr.
(Address) 1601 E. Preston St.

18. BURIAL, ~~CREMATION, OR REMOVAL~~
Place Mt. Calvary Date 11/9 1945

19. UNDERTAKER Elroy O. Wilson
(Address) 1000 Brentleyane

20. FILED NOV 19 1945 Huntington Williams Registrar

OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) 11/10/45

22. I HEREBY CERTIFY, That I attended deceased from Nov. 11 1945 to Nov. 17 1945

I last saw him alive on Nov. 10-45 Death is said to have occurred on the date stated above, at 9 P. m.

The principal cause of death and related causes of importance were as follows:

	Date of death
Asphyxia	3 hr
Broncho Pneumonia	2 ds

Other contributory causes of importance

Was an operation performed? Date of

For what disease or injury?

Name of operation

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? Date of injury 19

Where did injury occur?
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, state how

(Signed) E. H. Walters M. D.

(Address) 1443 E. Eager St.

X

G34276

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G34276 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5210 Edmondson Ave.
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5210 Edmondson Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Ella Clampitt Livingston

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife George W. Livingston

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 10, 1866

8. AGE: Years 79 | Months 10 | Days 7 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name Will Clampitt
13. Birthplace Md.

MOTHER
14. Maiden Name ?
15. Birthplace Md.

16 (a) Informant Mr. C. W. Livingston
(b) Address Round Bay, Severna Park, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/20/45 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location 3801 Frederick Ave.

18 (a) Funeral director John B. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) (Registrar) (b) Huntington Williams, M.D.

NOV 19 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 17 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from August 17 1945 to Nov 17 1945, and that I last saw h[illegible] alive on Nov 16 1945

Immediate cause of death: (a) Cerebral hemorrhage
Due to: Hypertension & Endocarditis

Due to:

Other Conditions: Hypostatic Pneumonia

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration: (a) unknown; 2 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address Medical Arts Bldg. Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. D.N. Fletcher

G34277

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 587

G34277 Registered No.

1. PLACE OF DEATH: 3rd fl.
(a) Baltimore City, Maryland
(b) Street address 1301 - Argle Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 6 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1301 - Argle Ave 3rd fl
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Florence Mary Smith

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-29-1925

8. AGE: Years	Months	Days	If less than one day
19 20	10	20	hr. min.

9. Birthplace Halifax Co. N. C.
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Frank Sleigh
13. Birthplace N.C.

MOTHER
14. Maiden Name Pattie Smith
15. Birthplace N.C.

16 (a) Informant Pattie Smith (Mother)
(b) Address 1301 - Argle Ave.

17 (a) Burial (b) Date thereof 11-21-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cemetery
Location Mt. Winans Md.

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

19 (a) NOV 19 1945 Huntington Williams, M.D.
Date rec'd by registrar Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-18 1945, at 10.05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/-5 1945 to 11-18 1945, and that I last saw h[illegible] alive on 11-17 1945.

Immediate cause of death	Duration
Rheumat. Heart Dis.	
Due to Rheumatic Fever	3 Yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature B. Z. Fletcher
Address 1118 Park Ave. Date signed 11/19/45 M D

VS 150

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34278

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 179X

G34278

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green
(c) Hospital or institution: University Hospital 25
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 14 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1347 Bender Court # 25
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Dorothy Speight

3 (b) If veteran, name war: Divorcee

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: —

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 4, 1944.

8. AGE: Years 1 | Months 14 | Days 14 | If less than one day: hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Willie Speight.
13. Birthplace Goldsboro, N.C.

MOTHER
14. Maiden Name Martie Barnes.
15. Birthplace Goldsboro, N.C.

16 (a) Informant Willie Speight.
(b) Address 1347 Binder Court.

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof Nov 20, '45 (month) (year)

(c) Cemetery or crematory
Location Wilson, N.C.

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 NOV 19 1945 (Date received by Local Registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 18 1945 at 8 55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 16 1945, to Nov. 18 1945, and that I last saw her alive on Nov. 17 1945.

Immediate cause of death	Duration
Chemical Pneumonia	2 Days
Due to Child drank paint	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Reese R. Bose, Jr. M. D.
Address University Hospital Date signed 11-18-45

Registered: Robert C. Fraites M.D.

G34279

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G34279

Every item of information should be carefully supplied. The
Please write PLAINLY, with UNFADING INK.
correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1939 Penrose Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 27 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore, Maryland
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1939 Penrose Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME BESSIE M. BOCKNER

3 (b) If veteran, name war	3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Frederick Bockner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 6, 1877

8. AGE: Years	Months	Days	If less than one day
67	11	12	hr. min.

9. Birthplace Grays, Balto. Co. Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William C. Cavey
13. Birthplace Maryland

MOTHER
14. Maiden Name Daut Meade
15. Birthplace Maryland

16 (a) Informant Mrs. Edna Harrison
(b) Address 2109 W. Lexington St.

17 (a) Burial (b) Date thereof Nov. 21, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Johns Cem.
Location Ellicott City, Md.

18 (a) Funeral director Easton Sons
(b) Address Ellicott City, Md.

NOV 19 1945
(Date rec'd by registrar) (b) Huntington Millington, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 18, 1945, at 8:45A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 4, 1942 to Nov. 18, 1945 and that I last saw her alive on Nov. 17, 1945

Immediate cause of death	Duration
Cardiac Insufficiency	6 wks.
Due to Diabetes Mellitus	
Due to Arteriosclerosis	?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George A. Kupp
Address 3030 Edmondson Ave. Date signed 11/19/45

X

G34280

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

G34280 Registered No.

Every item of information should be carefully supplied. The age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Duke and Layne
(c) Hospital or institution: W B G H.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 42.
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State N. Y. (b) County
(c) City or town Borodino
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY JANE NESBIT

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or ~~wife~~: Wallace Nesbit
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 14, 1864

8. AGE: Years 91 | Months 1 | Days 3 | If less than one day hr. min.

9. Birthplace New York. (Spafford)
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William T. Wilbur
13. Birthplace U. S. A.

MOTHER
14. Maiden Name Olive Orton
15. Birthplace U. S. A.

16 (a) Informant Mrs. Erford S. Norton
(b) Address 111 W. Mulberry St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11/20/45 (month) (day) (year)
(c) Cemetery or crematory
Location Borodino, N. Y.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (b)
(Date rec'd by registrar) Huntington Williams, M.D. Registrar

NOV 12 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-17 1945, at 4.15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-13 1945 to 11-17 1945; and that I last saw her alive on 11-17 1945:

Immediate cause of death	Duration
Congestive Heart Failure	
Due to Hypertensive-Arteriosclerotic Cardio-Vascular Disease	
Due to Pulmonary Gangrene.	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James A. Donkan M. D.
Address W. B. G. H. Date signed 11/17/45

X

G34281

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

G34281 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4100 Southern Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edward Hayes

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 154-01-9700

4. Sex: male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Carrie Hayes

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/15/1885

8. AGE: Years	Months	Days	If less than one day
59	11	1	hr. min.

9. Birthplace: Orleens Co., N. Y. (Town, county, and state)

10. Usual Occupation: Carpenter

11. Industry or business

FATHER
12. Name: Williard Hayes
13. Birthplace: N. Y.

MOTHER
14. Maiden Name: Elizabeth Arlington
15. Birthplace: England

16 (a) Informant: Mrs. Elizabeth Hayes, Mother
(b) Address: 816 Lincoln Place, Niagara Falls N.Y.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/20/45 (month) (day) (year)
(c) Cemetery or crematory: St. Peter's Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) Date received by registrar: Huntington Williams, M.D. Registrar

19 1945 VS-151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 16, 1945, at 2 P.M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Meningitis

Due to Fractured skull

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-10-45 at 6 A. M.
(b) Where did injury occur? 4100 Southern Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no
(d) Means of injury Fell down stairs

23. Signature Benedict Gutarelis M.D. Medical Examiner.
Date signed 11-17-45.

X

G34282 BALTIMORE CITY HEALTH DEPARTMENT X ✓ G34282

CERTIFICATE OF DEATH 1063

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Undertakers: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lankard & Green
(c) Hospital or institution: Univ. Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mo 4 d.
(e) Length of stay in Baltimore (yrs., mos., or days) 2 mo 4 d.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Wic.
(c) City or town Salisbury
(If outside city or town limits, write RURAL and give town)
(d) Street No. 113 E. Isabella St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George W. Truitt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Lena Truitt

6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) Aug. 26, 1897

8. AGE: Years 48 | Months 2 | Days 23 | If less than one day ? hr. ? min.

9. Birthplace Md. - Salisbury (Town, county and state)

10. Usual Occupation Repair Shop.

11. Industry or business

FATHER
12. Name Lee Truitt
13. Birthplace Salisbury, Md.

MOTHER
14. Maiden Name Ida Handman
15. Birthplace Salisbury, Md

16 (a) Informant Wife
(b) Address Salisbury, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-23-45 (month) (day) (year)
(c) Cemetery or crematory Parsons Cemetery
Location Salisbury, Md.

18 (a) Funeral director Holloway & Co.
(b) Address Salisbury, Md.

19 (a) NOV 20 1945 (b) Huntington-Wilkerson, M

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-19 1945, at 4 50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-5 1945, to 11-19 1945, and that I last saw him alive on 11-19 1945.

Immediate cause of death Cardiac Failure
Due to Pulmonary Edema
Due to Lung Abscess & Bronchiectasis
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Not done

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address Univ. Hosp. Date signed 11-19-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

~~G34483~~ Duplicate

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G34283 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette & John Street
(c) Hospital or institution: Hospital for Women of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 56
(e) Length of stay in Baltimore (yrs., mos., or days) 1 yr; 1d

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1325 Mount Royal
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) **FULL NAME** MRS. LUCY — McGAULY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. widow

6 (b) Name of husband or wife Walter J. McGAULY

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Feb 9, 1875

8. AGE: Years 70 | Months 9 | Days 16 | If less than one day ____ hr. ____ min.

9. Birthplace BAYOU LA FOURCHE, LOUISIANA
(Town, county, and state)

10. Usual Occupation Housekeeper

11. Industry or business

FATHER
12. Name unknown
13. Birthplace Louisiana

MOTHER
14. Maiden Name unknown
15. Birthplace Louisiana

16 (a) Informant Mrs George J. LeBlanc
(b) Address 1325 Mount Royal

Removal BURIAL (b) Date thereof 11/18/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory CALVARY
Location ST. LOUIS, MO.

18 (a) Funeral director WILLIAM COOK, INC.
(b) Address 1217 N. Calvert ST. Baltimore

19 (a) ____ (b) ____
(Date received by registrar)

NOV. 20 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH NOV 18 1945, at 10 30 M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 16 1945 to NOV 18 1945, and that I last saw ~~her~~ alive on NOV 18 1945

Immediate cause of death Bronchopneumonia, bilateral — Duration 2 days

Due to diabetes mellitus, acidosis — 7 yrs.

Due to diabetic gangrene left foot; cystitis, due to Staphylococcus

Other Conditions Antemortem hemorrhage, gluteal
(Include pregnancy within 3 months of death)

Date of operation ____

Major findings of operation: ____

of autopsy: ____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ____
(b) Date of occurrence ____ at ____ M.
(c) Where did injury occur? ____
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ____ While at work? ____
(Specify type of place)
(e) Means of injury ____

23. Signature J. Richard Compton, M.D.
Address Hospital for Women Date signed 11/19/45

G34284

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 10

Registered No. G34284

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Harford Rd & Herring Run
(c) Hospital or institution: Sydenham Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 1 yr 4 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2255 Hanover (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME James Albert Brown

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W Lib | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 22, 1941

8. AGE: Years 4 | Months 3 | Days 26 | If less than one day ..... hr. ..... min.

9. Birthplace Battle Creek Michigan (Town, county, and state)

10. Usual Occupation Child

11. Industry or business —

FATHER
12. Name William Brown
13. Birthplace Asheville, N. Car.

MOTHER
14. Maiden Name Beulah Lyons
15. Birthplace Estal Co. Kentucky

16 (a) Informant (Parents)
(b) Address 225 S. Hanover

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 11/20/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 127 St. Paul St.

NOV 20 1945 Date received by Local Registrar (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

35

20. DATE OF DEATH Nov. 17 1945, at 8 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 8 1945 to Nov. 17 1945, and that I last saw him alive on Nov. 17 1945.

Immediate cause of death	Duration
Cardiac failure	11 days
Due to Myocarditis	
Due to Diphtheria	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: — ✓

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Margaret H. D. Smith M. D.
Address Sydenham Hosp. Date signed 11-17-45

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34285

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 161C (367095) G34285

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution:
The Johns Hopkins Hospital 25-5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Curtis Bay
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6400 Arundel Cove
(If rural give location)
(e) Citizen of foreign country? .....(Yes or No)
If yes, name country .....

3 (a) FULL NAME Cooksey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife .....
6 (c) If alive, give age 10 years

7. Birth date of deceased (mo., day, yr.) November 11, 1945

8. AGE: Years	Months	Days	If less than one day
			7 hr. 37 min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation .....
11. Industry or business .....

FATHER
12. Name Harold Cooksey
13. Birthplace Kentucky

MOTHER
14. Maiden Name Virginia Jackson
15. Birthplace Kentucky

16 (a) Informant Hospital Records
(b) Address Johns Hopkins Hospital

17 (a) ..... (b) Date thereof .....
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory .....
Location Johns Hopkins Medical School NOV 17 1945

18 (a) Funeral director Commissioner of Health
(b) Address .....

19 NOV 20 1945 (Huntington Williams M.D.)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 10 1945, at 7:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from November 10 1945, to November 10 1945 and that I last saw him alive on November 10 1945.

Immediate cause of death erythroblastosis fetalis — Duration .....

Due to .....

Due to .....

Other Conditions .....
(Include pregnancy within 3 months of death)

Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M.
(c) Where did injury occur? .....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature Gilbert S. McVaugh M. D.
Address Johns Hopkins Hosp. Date signed 11-12-45

VS 150

F 3087 X

G34286 (350999)

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

160a

Registered No. G34286

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: The Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1528 Popland Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Kotek

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 10, 1945

8. AGE: Years	Months	Days	If less than one day
			10 hr. 16 min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Alvin Kotek
13. Birthplace Maryland

MOTHER
14. Maiden Name Delores Altevogt
15. Birthplace Maryland

16 (a) Informant Hospital Records
(b) Address Johns Hopkins Hospital

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School NOV 17 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) NOV 20 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 10 1945, at 3:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from November 10 1945, to November 10 1945, and that I last saw h er alive on November 10 1945.

Immediate cause of death? intracranial hemorrhage
? atelectasis — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Gilbert J. Vosburgh. M. D.
Address Johns Hopkins Hosp. Date signed 11-12-45

correct age is especially important. Physicians: please write the name of the cause of death clearly and legibly.

VS 150

3088

G34287

483252

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G34287

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: [illegible] 19
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1331 W. Pratt St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Miller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11. 7. 45

8. AGE: Years | Months | Days: 2 | If less than one day: hr. min.

9. Birthplace: md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joseph b Miller
13. Birthplace md

MOTHER
14. Maiden Name Irene Brinkley
15. Birthplace md

16 (a) Informant Record
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical Sch NOV 17 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 NOV 20 1945 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 9 1945 at 6.25 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 7 1945 to Nov 9 1945 and that I last saw him alive on Nov. 9 1945

Immediate cause of death Intracranial Hemorrhage? — Duration

Due to Hemorrhagic diptheria — 45 hrs.

Due to Prematurity

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. M. Harrison Jr. M. D.
Address Johns Hopkins Hosp Date signed 11/9/45

VS 150

3089

G34288

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1576

Registered No. G34288

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: W. B. & H
(d) Length of stay in hospital or inst. (yrs., mos., or days) 45m.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Balt (If outside city or town limits, write RURAL and give town)
(d) Street No. 9 Chesley St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Girl M'Carl

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11 16 45

8. AGE: Years	Months	Days	If less than one day
			hr. 45 min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Fred H. M'Carl
13. Birthplace Mapleton, Pa

MOTHER
14. Maiden Name Mary Yeager
15. Birthplace Balto Md.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School NOV 17 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) NOV 20 1945 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 16, 1945, at 7 15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 16 1945, to Nov 16 1945, and that I last saw her alive on Nov 16 1945

Immediate cause of death: Hydrops Fetalis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Enlarged Liver, Spleen, Kidney

of autopsy: Marked gen. edema

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Leo A. Hauer Jr. M. D.
Address 1 B. D. Date signed 11/16

PRINT WITH PENCIL, WITH CARBON INK. Every correct age is especially important. Physicians: please write the

VS 150

3090

G34289

BALTIMORE CITY HEALTH DEPARTMENT

HEP #96383

CERTIFICATE OF DEATH 93D

G34289 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 - 11 1 Mo. 11D
(e) Length of stay in Baltimore (yrs., mos., or days) 10 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6704 German Hill Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Iver Olli

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 14, 1893

8. AGE: Years	Months	Days	If less than one day
52	7	28	hr. min.

9. Birthplace Finland
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Isaac Olli
13. Birthplace Finland

MOTHER
14. Maiden Name Annie ?
15. Birthplace Finland

16 (a) Informant Balto., City Hospitals Records
(b) Address 4940 Eastern Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School NOV 19 1945

18 (a) Funeral director Commissioner of Health
(b) Address

NOV 20 1945 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

22. DATE OF DEATH Nov. 12, 1945, at 3:05 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1, 1945, to Nov. 12, 1945, and that I last saw h. 1m alive on Nov. 12, 1945.

Immediate cause of death	Duration
Bronchopneumonia	
Cardiac Failure	
Due to	
Arteriosclerotic Heart Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature I. P. Levington M.D.
Address Baltimore City Hosp. Date signed 11-14-45

VS 150

3091 X

634290

HKP #93157

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 D

634290 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 - 23
(e) Length of stay in Baltimore (yrs., mos., or days) ? ? ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 905 N. Parrish St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Branch

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5? ?/16?/89

8. AGE: Years	Months	Days	If less than one day
56?	6?	3?	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Adams Lassiter
13. Birthplace Md.

MOTHER
14. Maiden Name Miria Brooks
15. Birthplace ? ?

16 (a) Informant Balto. City Hospitals Records
(b) Address 4940 Eastern Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School NOV 19 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 NOV 20 1945 (Date rec'd by registrar) for Lillian Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 9, 1945, at 2:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 16, 1945 to Nov. 9, 1945 and that I last saw her alive on Nov. 9, 1945

Immediate cause of death: Coronary Thrombosis — Duration: 1/2 hr.
Due to: arteriosclerotic Heart Disease ?
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature T. P. Jennings M. D.
Address Baltimore City Hosp. Date signed 11-14-45

F3092

VS 150

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34291

BALTIMORE CITY HEALTH DEPARTMENT X V G34291

CERTIFICATE OF DEATH 159

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division st.
(c) Hospital or institution: provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) 11 days.

2. USUAL RESIDENCE OF DECEASED:
(a) State md. (b) County Baltimore
(c) City or town Baltimore Dundalk (If outside city or town limits, write RURAL and give town)
(d) Street No. 722 peach orchard lane (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country no

3 (a) FULL NAME michael Sheade fitzgerald

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	negro	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-26-45

8. AGE: Years	Months	Days	If less than one day
		11	hr. min.

9. Birthplace Balto. md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Edward Anderson fitzgerald
13. Birthplace Balto. md.

MOTHER 14. Maiden Name Pearl Aquila
15. Birthplace Balto. md.

16 (a) Informant Pearl fitzgerald
(b) Address 722 peach orchard Lane

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School NOV 19 1945

18 (a) Funeral director Commissioner of Health
(b) Address
NOV 20 1945 (Date rec'd by registrar) (Huntington Williams M.D.)

VB 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-7 1945, at 9 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-26 1945 to 11-7 1945, and that I last saw him alive on 11-7-1945

Immediate cause of death atelectasis — Duration

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. D.
Address 803 N. Fremont Date signed 11-17-45

3093 M.F. Wilson - 6034 N. Fremont ave.

These items are important, and full, accurate information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

AB-[illegible]2-92 — Registered No. 13[illegible]2-92

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals — 11
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 month 3days
(e) Length of stay in Baltimore (yrs., mos., or days) 50yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County — 4
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1211 Linden Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Hopkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 8-1871 or

8. AGE: Years	Months	Days	If less than one day
[illegible]or-74	9? 9	6? 10	hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

FATHER
12. Name Joseph Hopkins
13. Birthplace Virginia

MOTHER
14. Maiden Name Betty Dix
15. Birthplace Virginia

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 20/45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Cayuga Oak Ave

18 (a) Funeral director John Mitchell & Sons
(b) Address 1911 Eutaw Place

19 (a) (b)
(Signature of local registrar)

NOV 20 1945

VS 10

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 18- 1945, at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-15 1945, to 11-18 1945, and that I last saw him alive on 11-18- 1945.

Immediate cause of death: Cardiac failure — Duration

Due to: arteriosclerotic heart disease

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation: none

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature T. P. Jerrigan M. D.
Date signed 11-1945

Huntington Williams, M.D. Baltimore City Hosp.

PRINT ONLY IN PENCIL, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34293

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G34293 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2476 Shirley Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 15
(e) Length of stay in Baltimore (yrs., mos., or days) 22 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2476 Shirley Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ethel Grollman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Late Jacob
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1860

8. AGE: Years	Months	Days	If less than one day
85			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation
11. Industry or business None

FATHER
12. Name Samuel Watzman
13. Birthplace Russia

MOTHER
14. Maiden Name Zelda Margolis
15. Birthplace Russia

16 (a) Informant Claude H. Grollman
(b) Address Lubbock Texas

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 20, 1945 (month) (day) (year)
(c) Cemetery or crematory Aitz Chaim CongCem
Location Hebrew Washington Road Cemetery,

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) (Date rec'd by registrar) (b) Registrar

VS NOV 20 1945

MEDICAL CERTIFICATION 11.02

20. DATE OF DEATH November 20 1945 at P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 15 1945 to Nov 19 1945 and that I last saw h[er] alive on Nov 19 45

Immediate cause of death: Congestion heart failure — Duration 1 wk

Due to: chron myocarditis 2y

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M D Baylus

Address 2140 Eutaw Date signed 11/20/45

X

634294

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. 634294

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospl
(d) Length of stay in hospital or inst. (yrs., mos., or days) dec
(e) Length of stay in Baltimore (yrs., mos., or days) 32 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2708 Springhill Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hyman Berlin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Rose Berlin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-15-1877

8. AGE: Years	Months	Days	If less than one day
68 7	8	24	hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Ret

11. Industry or business

FATHER
12. Name —
13. Birthplace Russia

MOTHER
14. Maiden Name —
15. Birthplace Russia

16 (a) Informant Hus. Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-20-45 (month) (day) (year)
(c) Cemetery or crematory Oh Sh Adolph
Location

18 (a) Funeral director Lace Feiss Inc
(b) Address 1439 E. Balto St

19 (a) (Date rec'd by registrar) NOV 20 1945 Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 19 1945 at 12 Noon M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Generalized arteriosclerosis.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Eaton M.D.
Medical Examiner.
Date signed 11-19-45

VS 151

G34295

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D ✓

G34295 Registered No.

Type. Every item of information should be carefully supplied. Please write plainly, with UNFADING INK. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St. & Rutland Ave
(c) Hospital or institution Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 38 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4024 Swarmon Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ISRAEL Saperstein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Rose -

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years 66 | Months | Days | If less than one day hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation Textiles

11. Industry or business

FATHER
12. Name Isaac
13. Birthplace Russia

MOTHER
14. Maiden Name Rheindel
15. Birthplace Russia

16 (a) Informant Rose Saperstein
(b) Address 4024 Swarmon Ave.

17 (a) Burial (b) Date thereof 11-20-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Beth Hillel
Location Pimlico Mill Road

18 (a) Funeral director Jack Rewis Inc
(b) Address 1734 E. Balto. St.

NOV 20 1945 Harrington Williams M.D.
(Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-18 1945, at 5:55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-1 1945 to 11-18 1945 and that I last saw him alive on 11-18 1945.

Immediate cause of death	Duration
Cardiac failure -	
arteriosclerotic Heart disease	15 yrs?
Due to Coronary Occlusion?	
Due to myocardial fibrosis.	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Arnell Katz M. D.
Address Sinai Hosp. - Balt. Md. Date signed 11-19-45

634296

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 634296

Please answer questions 1 to 23 in ink. Write the causes of death clearly and legibly. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2802 Auchentoroly Ter
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2802 Auchentoroly Ter. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME David Tallin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Dora

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years 67 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Aaron
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Dora Green
(b) Address 2802 Auchentoroly Terrace

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-20-45 (month) (day) (yr.)
(c) Cemetery or crematory Shoare Tefiloh
Location Windsor Mill Road

18 (a) Funeral director Jack Lewis Inc
(b) Address 1409 E Balto St

19 NOV 20 1945 (Date rec'd by Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 19th 1945, at 8:35 A M.

21. I certify that I took charge of the remains described above, held an Autopsy & Inquest thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mullis M.D. Medical Examiner.
Date signed 11-19-45

VS 151

G34297

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G34297
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3307. Walbrook. Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town B-altimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2115 Lynhurst Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary. Storm

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife William Storm
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June-11-1863

8. AGE: Years	Months	Days	If less than one day
92	5	5	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Home Duties
11. Industry or business

FATHER
12. Name Andrew Mueller.
13. Birthplace Germany.

MOTHER
14. Maiden Name Catherine Buttenbrod
15. Birthplace Baltimore Md.

16 (a) Informant Mrs. Edgar Brockie
(b) Address 2115 Lynhurst-Ave

17 (a) Burial (b) Date thereof Nov. 20-1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western Cemetery
Location Baltimore Md.

18 (a) Funeral director Jeanie Cook Syfer
(b) Address 1600 W. North Ave.

19 (a) (Date rec'd by registrar) (b)

VS NOV 20 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 16 1945 at 11- P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/21 1942 to 11/16 1945, and that I last saw h[illegible] alive on 11/16 1945:

Immediate cause of death	Duration
Myocardial insufficiency	6 hrs.
Due to Arteriosclerosis	?
Due to Senility	?
Other Conditions.	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert A. Ratti M. D.
340 W Madison Ave
Date signed 11/19/45

I hereby certify that I attended the deceased from the date and to the date stated above, and that I last saw h[illegible] alive on the date stated above. Death occurred on the date stated above at 11 P.M. The cause of death was as stated above. Duration of disease was as stated above.

Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34298

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G34298

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) ½ hour
(e) Length of stay in Baltimore (yrs., mos., or days) ½ day

2. USUAL RESIDENCE OF DECEASED:
(a) State Va (b) County.....
(c) City or town Norfolk. (If outside city or town limits, write RURAL and give town)
(d) Street No. Cady Rd. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

3 (a) FULL NAME Nicholas Albano

3 (b) If veteran, name war: Spanish Am. War
3 (c) Social Security Account No. –

4. Sex: M
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Anna M. Albano
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Mar 13 1877
8. AGE: Years 68 | Months 8 | Days 19 | If less than one day .....hr. .....min.
9. Birthplace Italy (Town, county, and state)
10. Usual Occupation.....
11. Industry or business Restaurant Business

FATHER
12. Name Antonio Albano
13. Birthplace Italy

MOTHER
14. Maiden Name Anna Mazzei
15. Birthplace Italy

16 (a) Informant Charles C. Albano
(b) Address Norfolk - Virginia

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 20 45 (month) (day) (year)
(c) Cemetery or crematory St. Mary's
Location Norfolk - Va

18 (a) Funeral director Leonard J. Ruck
(b) Address 5365 Hanford Rd

19 (a) NOV 20 1845 (Date rec'd by registrar) Huntington Williams, Md. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/20 1945, at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/20 1945 to 11/20 1945, and that I last saw her alive on 11/20 1945.

Immediate cause of death	Duration
Coronary Occlusion	1 hour
Due to.....	
Due to.....	
Other Conditions.....	

(Include pregnancy within 3 months of death)

Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? ..... (Specify type of place)
(e) Means of injury.....

23. Signature W. H. Townsend Jr. M. D.
Address 14 E. Cary St Date signed 11/20

G34299

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G34295 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Park Ravenswood Blvd. ✓
(c) Hospital or institution: Lexington ave.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DEACEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4317 Mansfield Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles C. Shirley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Lottie M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 28. 1878

8. AGE: Years 66 | Months 11 | Days 21 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation P. R. R.

11. Industry or business conductor

FATHER
12. Name ✓
13. Birthplace ✓

MOTHER
14. Maiden Name ✓
15. Birthplace ✓

16 (a) Informant Mrs. Lottie M. Hammer
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-21-45 (month) (day) (year)
(c) Cemetery or crematory Baker
Location Aberdeen

18 (a) Funeral director Leonard J. Fuck
(b) Address 5805 Harford Rd

19 (a) NOV 20 1945 (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 19, 45 4 P. M.

21. I certify that I took charge of the remains described above, held an Inspection - Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardio - vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Spitalnic M.D. (Medical Examiner.)
Date signed November 19, 1945.

VS 151

G34300

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92B

G34300 Registered No. 63142

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution: U. S. Marine Hospital, Balto., Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 107 days
(e) Length of stay in Baltimore (yrs., mos., or days) 1yr. 3 months

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1524 Linden Ave. Balto., Md. (If rural give location)
(e) Citizen of foreign country? -- (Yes or No) If yes, name country

3 (a) FULL NAME Herbert Norman Lloyd

3 (b) If veteran, name war: --
3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	Haw.	single

6 (b) Name of husband or wife: --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 23, 1910

8. AGE: Years	Months	Days	If less than one day
35	5	25	hr. min.

9. Birthplace Honolulu, T. H. (Town, county, and state)
10. Usual Occupation Boatswain
11. Industry or business Seafarer

FATHER
12. Name Harry W. Lloyd
13. Birthplace Philadelphia, Pa.

MOTHER
14. Maiden Name Helen ?
15. Birthplace Hawaii

16 (a) Informant Records
(b) Address U. S. Marine Hospital, Balto. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 21 1945 (month) (day) (year)
(c) Cemetery or crematory Greene Mount Cemetery
Location York Rd. & Chuckle Lane

18 (a) Funeral director Odes Funeral Homes Inc
(b) Address 4644 York Rd

19 (a) (b) Hunting for Williams

NOV 20 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 18 1945, at 4:36 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 3 1945, to Nov. 18 1945, and that I last saw him alive on Nov. 18 1945.

Immediate cause of death	Duration
Endocarditis, chronic mitral stenosis (Rheumatic)	unknown
Due to	
Due to	
Other Conditions Abscess, pulmonary, right lower lobe. (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address Clinical Director Date signed 11/19/45
U. S. Marine Hospital, Balto., Md.

Please write plainly, with ink. Every item or information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634301

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 C

Registered No. 634301

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1030 N. Patterson Park Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1030 N. Patterson Park Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Phoebe Craig

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Harry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 8-1887

8. AGE: Years 58 | Months 3 | Days 11 | If less than one day hr. min.

9. Birthplace Canada (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Plain
13. Birthplace Canada

MOTHER
14. Maiden Name Don't Know
15. Birthplace Canada

16 (a) Informant Dethia Reuzel
(b) Address 1030 N. Patterson Park

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 23-45 (month) (day) (year)
(c) Cemetery or crematory Bab.
Location E. North. Ave

18 (a) Funeral director John. J. Hyde
(b) Address 3650 E. Balt. St.

19 (a) (Date rec'd by Local Registrar) Registrar

VS NOV 20 1945 Huntington Hill

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 19 1945, at 8:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1943, to Nov 19 1945, and that I last saw h-- alive on Nov 19 1945

Immediate cause of death: Carcinoma of Pancreas — Duration: 4 yrs

Due to: Secondary Carcinoma — Duration: 1 yr

Due to: of Stomach

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation 2 yrs ago.

Major findings of operation: Biopsy found Cancer cells

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Francis J. Hyde M. D.

Address 3005 E. Monument Date signed 11/19/45

X

G34302 Date obt'd by U.S.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1862

Registered No. G34302

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3520 Hilton Rd.
(c) Hospital or institution:
Hilton Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2810 Reisterstown Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANCES VIRGINIA GORDON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Charles G. Gordon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1, 1852

8. AGE: Years 93 | Months 5 | Days 17 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name William Worden
13. Birthplace England

MOTHER
14. Maiden Name Catherine Clee
15. Birthplace Unknown

16 (a) Informant Mr. Charles E. Gordon
(b) Address 2810 Reisterstown Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/20/45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

NOV 20 1945 (Date rec'd by Registrar)

(b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 18, 1945 at 5:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1943 to Nov 18 1945 and that I last saw her alive on Nov 17 1945

Immediate cause of death
Uraemia
Due to Cardio-vascular renal disease
Due to
Other Conditions Arteriosclerosis
Fracture of left femur
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration
2 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 15/11
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence Nov. 4th 1945 at A. M
(c) Where did injury occur? Hilton Nursing Home
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? no.
(Specify type of place)
(e) Means of injury Slipped & fell to floor.
23. Signature Chester J. Lubinski M.D.
Address 4710 Liberty Hts. Date signed 11/19/45

VS 150

Chester J. Lubinski, M.D. Per: Bernard Ostarello M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34303

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46D

G34303 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Eutaw Place
(c) Hospital or institution:
Elmhurst Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 600 St. Paul St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BERNARD (or Benjamin) BAER CROOKS

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	213-12-6723

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife -- 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 26, 1890

8. AGE: Years	Months	Days	If less than one day
55	2	22	hr. min.

9. Birthplace Keyser, W. Va.
(Town, county, and state)
10. Usual Occupation -- Clerk
11. Industry or business

FATHER
12. Name Norman J. Crooks
13. Birthplace Zanesville, Ohio

MOTHER
14. Maiden Name Emma Carroll
15. Birthplace Terre Alta, W. Va.

16 (a) Informant Mr. W. P. Crooks
(b) Address c/o C.A.Reid,Co.,225 Fifth Ave. New York City

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11/21/45 (month) (day) (year)
(c) Cemetery or crematory Queens Point Cem.
Location Keyser, W. Va.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 NOV 20 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 18, 19 45 at 9:15A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/15/45 19 to 11/17/45 19 and that I last saw him alive on 11/17/45 19

Immediate cause of death	Duration
respiratory failure	
Due to Carcinoma rectum	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury?

23. Signature I. Thorofsky M.D.
Address 6 o/ N. Monroe St. Date signed 11/20/45 M.D.

X

Spec.—2-20-28—L. F. S.—500 Blks.

G34304 G34304

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

27-1093D

1—PLACE OF DEATH REGISTERED NO.

CITY OF BALTIMORE: (No. 4409 York Road ST., 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME MAGDALENA ROHLFING

(a) RESIDENCE NO. 4409 York Road ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 3, 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	60	7	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER John M. Rohlfing

11 BIRTHPLACE OF FATHER (city or town) Baltimore, Md.
(State or country)

12 MAIDEN NAME OF MOTHER Saloma Schneider

13 BIRTHPLACE OF MOTHER (city or town) Baltimore, Md.
(State or country)

14 Informant Mr. George A. Rohlfing
(Address) 4409 York Rd.

15 NOV 20 1945 19 Huntington Williams, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Nov 18, 1945

17 I HEREBY CERTIFY, That I attended deceased from Oct 25, 19 45, to Nov 18, 19 45, that I last saw her alive on Nov 17, 19 45 and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows:

ARTERIO-SCLEROTIC
CARDIO VASCULAR
DISEASE (duration) SEVERAL yrs. mos. ds.

CONTRIBUTORY (Secondary) MYOCARDITIS (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? —

What test confirmed diagnosis? CLINICAL

(Signed) F. V. S. Mack, M. D.

11/18, 19 45 (Address) 513 East 39th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore — DATE OF BURIAL Nov 21 1945

20 UNDERTAKER Wm. S. Tiebout & Son — ADDRESS [illegible]

G34305
AB-97092

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

Registered No. G34305

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 310 N. Pulaski St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Andrest

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-01-2616

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept-6-1912

8. AGE: Years	Months	Days	If less than one day
33	2	12	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Henson
13. Birthplace Md.

MOTHER
14. Maiden Name Catherine ?
15. Birthplace ?

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/21/45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location

18 (a) Funeral director Thomas J. Kenny Inc
(b) Address Hollins & Gilmore Sts

19 (a) NOV 20 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 18- 1945, at 7 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-3- 1945, to 11-18 1945, and that I last saw her alive on 11-18- 1945.

Immediate cause of death Coronary Thrombosis — Duration
† Cachexia
Due to Ca of Cervix
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: —
of autopsy: No-Post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Eugene A. Pattenbet M. D.
Address B.C.H. Date signed 11-19 45

G34306

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1602

G34306 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto. General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 623 W. Lee St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Brunson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 18. 1945

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Spencer L. Brunson
13. Birthplace S.C.

MOTHER
14. Maiden Name Sarah E. Gross
15. Birthplace Bowie, Maryland

16 (a) Informant Spencer L Brunson
(b) Address 623 W. Lee Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 20 1945 (month) (day) (year)
(c) Cemetery or crematory Mount Lion.
Location Baltimore County.

18 (a) Funeral director Joseph A. Lively
(b) Address 404 N Mount St Baltimore City Md.

NOV 20 1945 (Date received by registrar) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 18 1945, at 7:20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxia

Due to Inhalation of Blood Amniotic Fluid & mucous.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh W.B. McNally M.D. Medical Examiner.
Date signed

X

G34307

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93 D

G34307 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3720 Belmont Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3720 Belmont Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Elizabeth Swain

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Frank Swain
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 1, 1861

8. AGE: Years	Months	Days	If less than one day
84	2 3	17	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Woolner
13. Birthplace Unknown

MOTHER
14. Maiden Name Fanny M Lee
15. Birthplace Ireland

16 (a) Informant Mrs Catherine Swain
(b) Address 3720 Belmont Ave

17 (a) Burial (b) Date thereof 11-21-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore Md

18 (a) Funeral director Fenton Bros
(b) Address 200 S Gilmor St

19 (a) NOV 20 1945 (b) Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 18 1945 at 9 16 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1945, to Nov 18 1945, and that I last saw her alive on Nov 17 1945.

Immediate cause of death: Uraemia Coma — Duration 2 days
Due to: Myocarditis
Due to: Arteriosclerosis
Other Conditions: Senility
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles J Wells M. D.
Address 5276 Park Heights Av Date signed Nov 20 45

VS 150

634308

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183

634308 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Fleet Street
(c) Hospital or institution: City Morgue
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1039 N. Carey st (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Oliver Spence

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years	Months	Days	If less than one day
53			hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Baltimore Md
13. Birthplace Daniel Spence Md

MOTHER
14. Maiden Name Sarah J. Martin
15. Birthplace Va

16 (a) Informant Dora Spence
(b) Address 1037 N Carey Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 20 45 (month) (day) (year)
(c) Cemetery or crematory Mt Zion Ct
Location Balto Co, Md

18 (a) Funeral director Isaiah L Brown & Son
(b) Address 108 W Montgomery St

19 (Date received) NOV 20 1945 (Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 15, 1945 at 12 Noon

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Found: Nov. 15, 1945 at 25/6 M.
(b) Where did injury occur? Found: Md. Drydock, Fairfield
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Found drowned

23. Signature Benedict Shitaneke M.D. Medical Examiner.
Date signed 11-15-45

VS 151

G34309

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. G34309

CWK-93909

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0- 5- 17- 16
(e) Length of stay in Baltimore (yrs., mos., or days) 6 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1420 Mosher Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fred Freeman

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 20-1923

8. AGE: Years	Months	Days	If less than one day
22	7	26	hr. min.

9. Birthplace South Carolina
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Milton Freeman (D)
13. Birthplace South Carolina

MOTHER
14. Maiden Name Mary Janes (D)
15. Birthplace South Carolina

16 (a) Informant Record-Baltimore City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Removal (b) Date thereof 11/20/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Anderson
Location S. C.

18 (a) Funeral director Isaiah L. Brown & Son
(b) Address 102 W Montgomery St

19 (a) NOV 20 1945 (b) Huntington Williams M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 16 1945, at 2 PM

21. I certify that death occurred on the date above stated; that I attended deceased from May 29 19 45 to Nov. 16 19 45, and that I last saw h im alive on Nov. 16 1945.

Immediate cause of death	Duration
Toxemia	2
Due to (1) Widespread Bone & Joint Tuberculosis with	
Due to (2) Cold Abscesses & Pulmonary Tuberculosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert B. Copeland Jr M. D.
Address Balt. City Hosp. Date signed 11/19/45

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

G34310

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V13B

G34310 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1230 Morling Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1230 Morling Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George Walter Wilson

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-22-3727

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Mary Gertrude Wilson

6 (c) If alive, give age 50 years

7. Birth date of deceased (month, day, year) Feb 20 1885

8. AGE: Years 60 | Months — | Days | If less than one day hr. min.

9. Birthplace Perryman Harford Co.
(Town, county and state)

10. Usual Occupation Superintendent

11. Industry or business Cemetery

FATHER 12. Name Charles Robert Wilson

13. Birthplace ?

MOTHER 14. Maiden name Mary Billingham

15. Birthplace Ireland

16 (a) Informant Mary G. Wilson.

(b) Address 1230 Morling Ave.

17 (a) Burial (b) Date thereof Nov 21 1945
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory St. Mary's

Location Hampden

18 (a) Funeral director Emanuel Funeral Home

(b) Address 2620 Eastern Ave.

NOV 20 1945
(Date rec'd by registrar)

(Name of cemetery) for Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 18 1945 at 11:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 22 1944 to Nov. 17 1945 and that I last saw h[illegible] alive on Nov. 6 1945.

Immediate cause of death	Duration
Cerebral Abscess	1940
Auricular fibrillation	1944
Due to Hypertension	1940
Arteriosclerosis	1940
Due to Pulmonary Tuberculosis	1944
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 600 Lexington Bldg. Date signed 11-5-45

VS 150

G34311

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G34311 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3228 Elmora Ave.
(c) Hospital or institution:

8-1

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3228 Elmora Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife Robert X. Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 2, 1871

8. AGE: Years	Months	Days	If less than one day
74	5	16	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Henry Mammen
13. Birthplace Germany

MOTHER
14. Maiden Name Marie Myers
15. Birthplace Germany

16 (a) Informant Mrs. Charles Krause
(b) Address 3228 Elmora Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/21/45 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location 7225 Eastern Ave.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 N. Broadway

NOV 20 1945 Date rec'd by local registrar Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 18, 1945 , at 1p M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-29- 1939 to 11-18- 1945, and that I last saw her alive on 11-18- 1945.

	Duration
Immediate cause of death Cardiovascular renal Disease	1939
Due to Generalise Arterio-sclerosis	1939
Due to	
Other Conditions Diabetes Mellitus	1939

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Milton C. Lang M. D.
Address 2117 Belair Date signed 11-20-45

VS 150

131a

G34312

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G34312

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2122 W. LEXINGTON ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V0
(e) Length of stay in Baltimore (yrs., mos., or days) 75/25.

2. USUAL RESIDENCE OF DECEASED:
(a) MD. (b) County
(c) City or town BALTIMORE.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2122 W. LEXINGTON ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HARRIETT FAUT — FAUT

3 (b) If veteran, name war	3 (c) Social Security Account No.
NONE	NONE.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
FEMALE	WHITE	WIDOWED

6 (b) Name of husband or wife GEORGE FAUT
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) OCT 20, 1858

8. AGE: Years	Months	Days	If less than one day
87	1 0	7 29	hr. min.

9. Birthplace FREDERICK, MARYLAND
(Town, county, and state)
10. Usual Occupation HOUSE WIFE
11. Industry or business OWN HOME

FATHER
12. Name JAMES A. ESWORTHY
13. Birthplace MARYLAND

MOTHER
14. Maiden Name MARY WEAGALES
15. Birthplace FREDERICK MD.

16 (a) Informant LUCRETIA SMITH
(b) Address 2122 W. LEXINGTON ST.

17 (a) BURIAL (b) Date thereof 11/29/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory MT. OLIVET CEM.
Location FREDERICK, MD.

18 (a) Funeral director Goodman, Jno.
(b) Address 414 N. Franklintown Rd.
(c) NOV 30 1945 Huntington Williams M.D.
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH NOV. 19 1945, at 330 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/1 1945 to 11/19 1945
and that I last saw her alive on 11/15 1945

Immediate cause of death	Duration
(a) Myocarditis	2 yrs
Due to (b) Arterio Sclerosis	
Due to (c) Hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward Asher M. D.
Address 2145 W. Baltimore Date signed 11/30/45

Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The correct age is especially important.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34313

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93 D

G34313
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Caldbrown
(c) Hospital or institution:
Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2552 Hollins St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Holthaus { anna mw. Holthaus }
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: August Holthaus
6 (c) If alive, give age 46 years
7. Birth date of deceased (mo., day, yr.) Nov 19 1907
8. AGE: Years 37 | Months 11 | Days 28 | If less than one day: hr. min.
9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Hsewife
11. Industry or business —

FATHER
12. Name Michael Brandel
13. Birthplace Germany

MOTHER
14. Maiden Name Sophia F. Fiddle
15. Birthplace Germany

16 (a) Informant August Holthaus
(b) Address 2552 Hollins St
17 (a) Burial, cremation, or removal Baltimore (b) Date thereof 11 21 45 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cemetery
Location Baltimore Md
18 (a) Funeral director J. B. Wilkinson & Son
(b) Address 850 W. Baltimore St
19 (a) (Date rec'd by registrar) NOV. 20 1945 (b) Huntington Nottingham Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 17 1945, at 7.46 PM
21. I certify that death occurred on the date above stated; that I attended deceased from Nov 17 1945 to Nov 17 1945, and that I last saw h e alive on Nov 17 1945.

Immediate cause of death	Duration
Cerebral Accident	
Due to Hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature H. K. Kerrison
Address Franklin Square Hosp Date signed M. D.

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34314

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83 B G84404

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 11 N. Fulton Av
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 11 N. Fulton Av (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Adeline Herbert

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Stephen J. Herbert

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 29-1867

8. AGE: Years 78 | Months 5 | Days 18 | If less than one day ____ hr. ____ min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Steinfeld
13. Birthplace Germany

MOTHER
14. Maiden Name —
15. Birthplace Germany

16 (a) Informant Amelia S. Thrun
(b) Address 11 N. Fulton Av.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/20/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director J. B. Hilgenbrink Son
(b) Address Baltimore Maryland

19 (a) (Date rec'd by registrar) (b) Registrar

VS 10 NOV 20 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/17/45 at 8:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 31 1943 to Nov. 17 1945 and that I last saw her alive on Nov. 14 1945

Immediate cause of death Cerebral Thrombosis — Duration 2 weeks

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
(f) Signature Leonard Yaffe M. D.
Address 3101 W Baltimore Date signed

X

NOV 19 1945

G34515

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. G34515

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2205 W. Pratt St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) Died
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2205 W. Pratt St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Koester {HENRY KOESTER}

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Mary Koester

6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) 11/25/1890

8. AGE: Years	Months	Days	If less than one day
54	11	19	4 hr. min.

9. Birthplace Baltimore Md
(Town, county, and State)

10. Usual Occupation Structural Steel Worker

11. Industry or business Bethlehem Steel Co

FATHER
12. Name Henry Koester
13. Birthplace Md

MOTHER
14. Maiden Name Louise Fiskow
15. Birthplace Md

16 (a) Informant Mary Koester
(b) Address 2205 W. Pratt St

17 (a) Burial (b) Date thereof 11/25/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location Baltimore, Md

18 (a) Funeral director J. A. Humphreys Sons
(b) Address 1550 W. Baltimore St

19 (a) NOV 24 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/19 1944, at 10:50 P.M.

21. I certify that I took charge of the remains described above, held an Inspection-Examination and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature P. J. Sulivan M.D.
Medical Examiner.
Date signed 11/20/44

VS 151

G34316

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83 B

G34316 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be filled in. Information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 228 S. Gilmor St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 6 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 228 So Gilmor St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosa V. Nichols

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct 9-1869

8. AGE: Years 76 | Months 1 | Days 8 | If less than one day hr. min.

9. Birthplace a.a. a Md (Town, county, and state)

10. Usual Occupation At Home.

11. Industry or business —

FATHER
12. Name Isaac W. Nichols
13. Birthplace Md

MOTHER
14. Maiden Name Amanda Lusby
15. Birthplace Md

16 (a) Informant Mrs. Lillie B. Joyce
(b) Address 228 S. Gilmor St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/20/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park.
Location Balto Md

18 (a) Funeral director Leg. L. Boyer Jr
(b) Address 512 Hollins St

19 (a) (Date received by registrar) NOV 20 1945 (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-17-1945 at 5 — P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-16-1945 to 11-17-1945; and that I last saw her alive on 11-17-1945.

Immediate cause of death: Cerebral Thrombosis — Duration one day

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. B. Schneider M. D.
Address 54 S. Fulton Ave Date signed 11-19-45

X

G34317

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 148

G34317 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3520 N. Hilton St.
(c) Hospital or institution: Ashburton House 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3wks
(e) Length of stay in Baltimore (yrs., mos., or days) 2yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Hagerstown 5
(If outside city or town limits, write RURAL and give town)
(d) Street No. ###### (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME: RUTH VIOLA SHIRLEY

3 (b) If veteran, name war: ##
3 (c) Social Security Account No. ##

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Wm. E. Shirley
6 (c) If alive, give age 41 years

7. Birth date of deceased (mo., day, yr.) Nov. 25, 1901

8. AGE: Years	Months	Days	If less than one day
43	11	23	hr. min.

9. Birthplace Hagerstown, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Charles Delaughter
13. Birthplace Maryland

MOTHER
14. Maiden Name (?) Hartle
15. Birthplace Maryland

16 (a) Informant William E. Shirley
(b) Address 312 E. Lafayette St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 21 Nov 45 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Baltimore, Md.

18 (a) Funeral director Walter Brooks Bradley
(b) Address 1922 W. North Avenue

19 (a) (Date received by registrar) NOV 20 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH November 18 1945, at 6 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 15 1944, to Nov. 18 1945, and that I last saw her alive on Nov. 18 1945.

Immediate cause of death	Duration
Carcinoma of cervix uteri with abdominal metastases	2 yrs.
Due to	
Due to	
Other Conditions Rectovaginal fistula	1 yr.

(Include pregnancy within 3 months of death)
Date of operation October 8
Major findings of operation: Metastatic carcinoma aortic & pelvic nodes.
of autopsy: Not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature David B. Cheek M. D.
Address Johns Hopkins Hospital Date signed November 19, 1945

Hunting for Mother's maiden name

VS 150

G34318

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G34318 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 7310 Old Harford Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 7310 Old Harford Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Louis W. Kramer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	widower

6 (b) Name of husband or wife Marie D. Nordmeier
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 6, 1863

8. AGE: Years	Months	Days	If less than one day
82	10	12	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER 12. Name Unknown
13. Birthplace "

MOTHER 14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs Marie Graeff
(b) Address 2908 Glenmore Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 21, 1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Ave.

18 (a) Funeral director John F. Deegy, Inc.
(b) Address 715 Light St.

NOV 20 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 18 1945; at 10.45 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1945 to Nov 18 1945 and that I last saw h(im) alive on Sept 1945

Immediate cause of death	Heart failure	
Due to	Arteriosclerotic C-V disease	
Due to		
Other Conditions		

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas P Brennan M. D.
Address 5217 Harford Rd Date signed 11-19-45

X

G34319

BALTIMORE CITY HEALTH DEPARTMENT Clarion
CERTIFICATE OF DEATH 122B

G34319
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkins & Caton Aves
(c) Hospital or institution:
St Agnes Hospital yes
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) ~~CHANGED~~

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3432 Fredrick Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Clarion V. Vinson ~~CHANGED~~

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife John King Vinson
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) April 10, 1869

8. AGE: Years 76 | Months 7 | Days 7 | If less than one day ... hr. ... min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Joseph Hershberger
13. Birthplace Maryland

MOTHER
14. Maiden Name Rebecca Howard
15. Birthplace Maryland

16 (a) Informant Daughter Bertha Kersten
(b) Address 3432 Fredrick Ave

17 (a) Burial (b) Date thereof 11/21/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Broadfording Church Cem
Location Route 40, Hagerstown

18 (a) Funeral director John F Hildebrand, Inc
(b) Address 115 Light St

19 (a) (b) Huntington Williams M.D.
(Date rec'd by registrar)

NOV 20 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/17 1945, at 6:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/1 1945 to 11/17 1945, and that I last saw h[illegible] alive on 11/17 1945.

Immediate cause of death: Respiratory failure — Duration

Due to Overwhelming Pneumonia

Due to Massive Bed Operative Atelectasis and Dry Gangrene of Left foot.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Nov 2, 1945

Major findings of operation: Partial resect Stomach from adhesions

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chas E. Carl Jr

Address Date signed 11/18/45

X

G34320

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 D

G34360 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd. + Calvert St.
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days) 60

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore.
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Ambassador Apts. City-18
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mr. John Henry Hughes

3 (b) If veteran, name war No. | 3 (c) Social Security Account No 286-09-0565

4. Sex M. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Married.

6 (b) Name of husband or wife Mrs. J. H. Hughes.
6 (c) If alive, give age 7 years

7. Birth date of deceased (mo., day, yr.) 4/23/1883

8. AGE: Years 62 | Months 6 | Days 27 | If less than one day 1 hr. 56 min.

9. Birthplace Maryland. (Town, county, and state)

10. Usual Occupation Retired.

11. Industry or business

FATHER
12. Name William Hughes (d)
13. Birthplace Maryland.

MOTHER
14. Maiden Name Holmes (d)
15. Birthplace Maryland.

16 (a) Informant Mrs. J. H. Hughes.
(b) Address Ambassador Apts. City-18

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/23/45 (month) (day) (year)
(c) Cemetery or crematory Chester Cem.
Location Chestertown, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

NOV 20 1945 (Date filed by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 20 1945, at 12:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/9/45 19... to 11/20/45 19..., and that I last saw h.. alive on 11/20/45 19....

Immediate cause of death	Duration
Respiratory Failure	
Due to Uremia - Acute (Accident Hemorrhage)	11 d.
Due to HC-V-H	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. L. Sanders M. D.
Address Union Memorial Hosp. signed 11/20/45

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634381

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1931

634381
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert st.
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 66

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balt.
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 313 Woodlawn Rd. City
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Germany

3 (a) FULL NAME CLARA MURRAY

3 (b) If veteran, name war: 0
3 (c) Social Security Account No.: 0

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Rev. Waldo Emerson Murray
6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) March 16, 1874

8. AGE: Years 66 | Months 8 | Days 3 | If less than one day ....hr. ....min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Housewife.
11. Industry or business 0

FATHER
12. Name William Diralla
13. Birthplace Germany

MOTHER
14. Maiden Name Concordia Schiedmann
15. Birthplace Germany

16 (a) Informant Patient.
(b) Address 313 Woodlawn Rd. City-10

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11/20/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Hope
Location Rochester, N. Y.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

NOV 20 1945 (Date received by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 19 1945, at 10:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/3/45 19.... to 11/19/45 ....; and that I last saw h.. alive on 11/14/45 19....

Immediate cause of death	Duration
Angina Pectoris	
Due to Hypertensive Cardio-Vas. Disease.	1
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 0
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ....at .... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. B. Sandin M.D.
Address Union Memorial Date signed 11/19/45

X

634322

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 33 B

Registered No. 634322

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution:
South Baltimore General Hospital 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1day
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 344 S. Calhoun St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Walter B. Hall

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/30/1901

8. AGE: Years	Months	Days	If less than one day
44	3	21	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Shoemaker
11. Industry or business Self

FATHER
12. Name Emanuel Hall
13. Birthplace Maryland

MOTHER
14. Maiden Name Ella Jennings
15. Birthplace Maryland

16 (a) Informant Mrs Laura Grace Hickett
(b) Address 1515 McHenry Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 23 1945 (month) (day) (year)
(c) Cemetery or crematory Western Cemetery
Location Baltimore, Md.

18 (a) Funeral director Willis Donovan
(b) Address 1093 N. Baltimore St

NOV 21 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 20, 1945, at 2:32 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 19, 1945 to Nov. 20, 1945, and that I last saw him alive on 11/20 1945

Immediate cause of death	Duration
Infectious Neuronitis	5days
Due to Possible Influenza	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Daniel Ehrlich M. D.
Address 1213 Light St. Date signed 11-20-45

G34323 ✓ G34323

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto. Hosp. 5-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) Died
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1643 N. Fulton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edna F. Sauers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed or divorced~~.
Female	White	Married

6 (b) Name of husband George F. Sauers

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 19th 1890

8. AGE: Years	Months	Days	If less than one day
55	10	1	hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Own Home

FATHER
12. Name Edward M. Abell
13. Birthplace Maryland

MOTHER
14. Maiden Name Sarah A
15. Birthplace Maryland

16 (a) Informant George F. Sauers
(b) Address 1643 N. Fulton Ave.

17 (a) Burial (b) Date thereof Nov 21-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Road

18 (a) Funeral director William Cook Inc.
(b) Address 1217 N. Paul Street

19 (a) (Date rec'd by registrar) (b) Registrar

NOV 21 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 20th 1945, at 2 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion.

Due to

Other Conditions Arteriosclerosis.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skiarchi M.D.
Medical Examiner.
Date signed 11-20-45

X

G34324 BALTIMORE CITY HEALTH DEPARTMENT G34324
CERTIFICATE OF DEATH 170C Registered No.

write the causes of death clearly and legibly. Physicians: please write

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N.Y. (b) County
(c) City or town Brooklyn (If outside city or town limits, write RURAL and give town)
(d) Street No. 140 Columbia Heights (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Allan S. Semple

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of ~~husband~~ wife: Rachel B. Semple

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 29th 1875

8. AGE: Years	Months	Days	If less than one day
69	10	21	hr. min.

9. Birthplace: Glasgow, Scotland (Town, county, and state)
10. Usual Occupation: Accountant
11. Industry or business: Own

FATHER
12. Name: David Semple
13. Birthplace: Scotland

MOTHER
14. Maiden Name: Elizabeth Stewart
15. Birthplace: Glasgow Scotland

16 (a) Informant: Robt. A. Semple (Brother)
(b) Address: 45 Greenwood Drive Millburn N.J.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 11/23/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~: Cathedral
Location: Balto. Md.

18 (a) Funeral director: William Cook Inc.
(b) Address: 1217 St. Paul St.

19 (a) (Date received by registrar) (b) Huntington Williams, M.D. Registrar

NOV 21 1945

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 20, 1945, at 1 45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Fractured cervical vertebrae

Due to:

Other Conditions: Fractured pelvis, multiple bruises, lacerations, etc. Fracture, leg, tibia. (Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-19-45 8 45 P.M. 12/6
(b) Where did injury occur: Charles & 25th Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No.
(d) Means of injury: Pedestrian struck by auto

23. Signature: Howard J. Mallis M.D. Medical Examiner.
Date signed 11-20-45

X

G34325

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G34325 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 851 Hillman Court
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County City Balto
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 851 Hillman Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Anna H. Painter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Louis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 9-1865

8. AGE: Years 80 | Months 9 | Days 10 | If less than one day hr. min.

9. Birthplace Alexander Va
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name James C. Grimes
13. Birthplace Va

MOTHER
14. Maiden Name Louise
15. Birthplace Va

16 (a) Informant Samuel H. Walter
(b) Address 1218 East Federal St

17 (a) Burial (b) Date thereof Nov 21-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location Frederick Road

18 (a) Funeral director William Cook Inc
(b) Address 217 St Paul St Balto Md

19 (a) (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS/15

NOV 24 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 19 1945 at 8:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1945, to Nov 19 1945, and that I last saw h[er] alive on Nov 19 1945

Immediate cause of death

Cerebral Hemorrhage — Duration: 1 hr.

Due to Chronic Cardio Vascular Disease — Duration: 5 yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank J Ayd M. D.
Address 2006 E. Monument St Date signed 11/30/45

X

Please write in ink, firmly, without erasing. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634326

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

150c

Registered No. 634326

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1226 Division St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1226 Division St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Dorothy Elizabeth White S33237

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Colored

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Saul

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 1, 1924

8. AGE: Years 21 | Months — | Days 17 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Arthur Wallace
13. Birthplace Rejlerstown, Md

MOTHER
14. Maiden Name Ida Hammond
15. Birthplace Towson, Md

16 (a) Informant Mrs. Dorothy Wallace
(b) Address 1226 Division St.

17 (a) Burial (b) Date thereof Nov. 21 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore Md

18 (a) Funeral director Thos. Lowery A. Holland
(b) Address 1631 Druid Hill Ave.

NOV 21 1945 (Date rec'd by registrar) Registrar Washington, D.C.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/18/45 19 , at 6 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/15/45 to 11/18/45, 19 ; and that I last saw living alive on 11/18/45, 19

Immediate cause of death: Cerebral thrombosis

Duration: 3 days

Due to Following a normal birth

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Thos. Lowery Ellison M. D.
Address 2 W. Mt. Royal Ave. Baltimore

VS 150

G34327

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G34327
Registered No.

Item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1518 Aisquith Street
(c) Hospital or institution:

9-9

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1518 Aisquith Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles E. Tinker Sr.

3 (b) If veteran, name war: None
3 (c) Social Security Account No. 212-16-9200

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Rose L. Moran
6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) March 13, 1881

8. AGE: Years 64 | Months 8 | Days 5 | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Baltimore Transit Co.

FATHER
12. Name Robert F. Tinker
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary E. Walston
15. Birthplace Baltimore, Md.

16 (a) Informant Charles E. Tinker Jr. (Son)
(b) Address 1504 Aisquith Street

17 (a) Burial (b) Date thereof 11/22/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Baltimore County

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) NOV 21 1945
(Date received) Registrar

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/18/45 19 ... at 10 40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 10 1945 to Nov. 18 1945; and that I last saw him alive on Nov. 17, 1945.

Immediate cause of death: Coronary Thrombosis — Duration: 8 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M.D.
Address 1331 E. North Ave. Date signed 11-18-45

X

G34328

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

53

G34328

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Wilkins & Caton Aves

(c) Hospital or institution: St Agnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-5

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County B

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1208 Harley Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Mateldas Vogelsong

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Leo H

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 23 1883

8. AGE: Years	Months	Days	If less than one day
62	-	27	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Christopher Rosendale

13. Birthplace Maryland

MOTHER 14. Maiden Name Mary Robinson

15. Birthplace Maryland

16 (a) Informant Husband Leo H

(b) Address 1208 Harley Ave (11)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-30-45 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Balto.

18 (a) Funeral director Leonard J. Rusk

(b) Address 5305 Harford Rd, Balto, Md

19 NOV 21 1945 (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/28 1945 at 7:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/8 1945 to 11/30 1945 and that I last saw her alive on 11/28 1945.

Immediate cause of death	Duration
Cardio Respiratory failure	
Due to carcinomatosis	
Due to Mitosis - Sarcoma	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Carcinomatosis Bx

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Cliff Rosendale, Jr.

Address St Agnes Hosp Date signed 11/29/45 M. D.

VS 150

Dr. C. H. Meyers
1520 E. 33rd St.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93D

Registered No. 32429

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2919 Shirey Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2919 Shirey Avenue -14- (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gertrude A. Baker

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Louis Baker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 20, 1880

8. AGE: Years 65 | Months 8 | Days 30 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Henry C. Parrish
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Ann Matthews
15. Birthplace Md.

16 (a) Informant Mr. Louis Baker
(b) Address 2919 Shirey Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/22/45 (month) (day) (year)
(c) Cemetery or crematory Stm Mary's Cem.
Location Govans, Maryland

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) (Date rec'd by registrar) (b) Huntington Hdwe., Md.

VS 180 NOV 21 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 19 1945 at 9 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 18 1945 to Nov. 19 1945 and that I last saw h alive on Nov 19 1945

Immediate cause of death	Duration
Acute Coronary Occlusion	1 day
Due to: Chr. Myocarditis.	3 mos.?
Due to: ✓	
Other Conditions Chr. Nephritis	1 yr.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. H. Meyers M. D.
Address 1520 E. 33rd Date signed 11/19/45

X

G34330 ✓ G34330

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 705 N. Carrollton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 48.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 705 N. Carrollton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence F. Gross

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: M

6 (b) Name of ~~husband~~ or wife Ann E. Gross
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 8 1897

8. AGE: Years 48 | Months 7 | Days 10 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, or State)

10. Usual Occupation School Teacher

11. Industry or business

FATHER 12. Name Milton Gross
13. Birthplace Md

MOTHER 14. Maiden Name Alice Talbert
15. Birthplace Md

16 (a) Informant Ann. E. Gross
(b) Address 705 N. Carrollton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-22-45 (month) (day) (year)
(c) Cemetery or crematory Arlington
Location Balto. Co.

18 (a) Funeral director Samuel McChesney & Son
(b) Address 638 N. Gilmor St.

19 (a) NOV 21 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 - 18 1945 at 7:22 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2-17 1945 to 11-18 1945 and that I last saw h~~e~~ alive on 11-16 1945

Immediate cause of death	Duration
Cardio-Vascular-Renal Disease	Severe years
Due to —	
Due to —	
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury —

23. Signature H. H. Slaughter M. D.
Address 825 N. Fremont Ave Date signed 11-20-45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34331

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G34331

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4813 Pennington Ave
(c) Hospital or institution:

(d) Length of stay in hospital of inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4813 Pennington Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME C. Gaither Cheek

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1895

8. AGE: Years	Months	Days	If less than one day
50			hr. min.

9. Birthplace North Carolina
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Samuel W Cheek
13. Birthplace North Carolina

MOTHER
14. Maiden Name Donna Gregory
15. Birthplace North Carolina

16 (a) Informant

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 23 45 (month) (day) (year)

(c) Cemetery or crematory Sunset Cemetery Co.
Location Winston Salem N C

18 (a) Funeral director Oddy Funeral Home Inc
(b) Address 4644 York Rd

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D.

NOV 21 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 19 1945, at 10 50 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert M Gaither M.D.
Medical Examiner.
Date signed Nov. 19 1945

the causes of death clearly and legibly. Physicians: please write

G34332

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G34332

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 260 S. Robinson St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 260 S. Robinson
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles A. Zaharda or (Doyle)

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 215-03-2914A

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Augusta

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Aug 11 - 1877

8. AGE: Years: 68 | Months: 3 | Days: 4 | If less than one day: hr. min.

9. Birthplace: Basto
(Town, county, and state)

10. Usual Occupation:

11. Industry or business: Retired

FATHER
12. Name: Frank Zacharda
13. Birthplace:

MOTHER
14. Maiden Name: Mary
15. Birthplace:

16 (a) Informant: Frances Meinecke
(b) Address: 260 S. Robinson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/23/45 (month) (day) (year)
(c) Cemetery or crematory: Oak Hill
Location: Lane (Phila. Rd.)

18 (a) Funeral director: M. W. B. Dippel's Sons
(b) Address: Lombard & Haw Sts.

19 (a) Date received by registrar NOV 24 1945 (b) Registrar: Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 19 1945, at 7:15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1 1945 to Nov. 19 1945, and that I last saw h / x alive on Nov. 19 1945

Immediate cause of death: Chronic Myocarditis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Joseph Zachary M.D.

Address 441 W Ellwood Av Date signed 11/24/45

G34333

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121a

G34333 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4220 Vermont Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4220 Vermont Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME N. TIPTON SLEE

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Sadie P. Slee
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 29, 1857

8. AGE: Years	Months	Days	If less than one day
87	10	20	hr. min.

9. Birthplace Near Churchville, Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name George W. Slee
13. Birthplace Harford Co., Md.

MOTHER
14. Maiden Name Mary Evans
15. Birthplace Churchville, Md.

16 (a) Informant Miss Jessie Slee
(b) Address 4220 Vermont Ave.

17 (a) Burial (b) Date thereof 11/21/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Spesutie
Location Perryman, Harford Co., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 21 1945 Huntington Williams, M.D.
(Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 19, 1945, at 6:45 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1943 to Nov 19 1945, and that I last saw him alive on Nov 19 1945.

Immediate cause of death	Duration
Cardio vascular renal disease	
Due to Senility	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature H. H. Crawford M. D.
Address 4209 Hend Ave Date signed 11/20/45

VS 180

G34334

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

G34334 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3570 N. Hilton Rd
(c) Hospital or institution:
Hilton Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 67 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Glen Burnie
(If outside city or town limits, write RURAL and give town)
(d) Street No. Crane Highway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julia Wright Hamlen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	married

6 (b) Name of husband or wife Albert Hamlen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 16, 1876

8. AGE: Years	Months	Days	If less than one day
69	8	2	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Herman Zaiser
13. Birthplace Germany

MOTHER
14. Maiden Name Caroline Fuchs
15. Birthplace Germany

16 (a) Informant Mr Albert Hamlen
(b) Address Glen Burnie

17 (a) Burial (b) Date thereof 11/24/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3801 Frederick Rd

18 (a) Funeral director Harry A Wirtz
(b) Address 1016 Edmondson Ave.

19 (a) NOV 21 1945 ington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 18 1945, at 5:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 7, 1945 to Nov. 18, 1945
and that I last saw h alive on Nov. 17, 1945.

Immediate cause of death Spleno-myelogenous-leukemia — Duration 6 mo.
from history

Due to

Due to

Other Conditions Spleno-myelogenous-leukemia-from history -6 mo.
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury

23. Signature Walter S Tiblett

Address 2220 Garrison Blvd. Date signed 11/26/45 M. D.

X

G34335

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G34335

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5419 Pembroke ave
(c) Hospital or institution:
27-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5419 Pembroke ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Elizabeth Kelly

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	widow

6 (b) Name of husband or wife late Henry Kelly
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 20, 1870

8. AGE: Years	Months	Days	If less than one day
75	7	1	hr. min.

9. Birthplace Delaware (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name James Collins
13. Birthplace Delaware

MOTHER
14. Maiden Name Ann Hastings
15. Birthplace Delaware

16 (a) Informant Mrs. Carrie Thompson
(b) Address 5419 Pembroke

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/21/45 (month) (day) (year)
(c) Cemetery or crematory St Pauls
Location Violetonville

18 (a) Funeral director Harry A. Wetzka
(b) Address 4112 Edmondson ave

19 (a) NOV 21 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/17 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/10 1945 to 11/17 1945, and that I last saw h[er] alive on 11/16 1945.

Immediate cause of death	Duration
Cerebral Hemorrhage	3 days
Uremia	2 hours
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sol Smith
Address 1223 E. Northern Date signed 11/20/45 M. D.

X

READ WHITE LETTERS, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634336

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55 C

634336 Registered No.

PRINT WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 616 W.40th St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13-7
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 616 W.40th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Henry Burns

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-05-2245

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary Elizabeth Burns
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 25 1872

8. AGE: Years	Months	Days	If less than one day
73	6	26	hr. min.

9. Birthplace Baltimore Co.Md. (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business Robt Garrett Son's

FATHER
12. Name John Burns
13. Birthplace Baltimore Co.Md.

MOTHER
14. Maiden Name Bridget Hagerty
15. Birthplace Ireland

16 (a) Informant Mary E.Burns
(b) Address 616 W.40th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 23 1945 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore Md.

18 (a) Funeral director Harry A. Winnacott
(b) Address 4204 Ridgewood Ave

19 NOV 21 1945 (Date rec'd by registrar) Huntington Woodlawn, Md.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 20 1945, at 5:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 14 1945, to Nov. 20 1945, and that I last saw h[illegible] alive on Nov. 19 1945.

Immediate cause of death	Duration
Carcinoma of Thyroid Gland	1 yr.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry O. Kelly M. D.
Address 2504 Aisquith St Date signed 11-24-45.

G34337

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G34337

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Monument St. & Rutland Ave

(c) Hospital or institution: Sinai Hospital 15-2

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 35 Years

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto (If outside city or town limits, write RURAL and give town)

(d) Street No. 1705 N. Pulaski St (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) **FULL NAME** Hyman Minsberg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ray Minsberg

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1890

8. AGE: Years 55 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county and state)

10. Usual Occupation Junk Dealer

11. Industry or business

FATHER

12. Name —

13. Birthplace Russia

MOTHER

14. Maiden Name —

15. Birthplace Russia

16 (a) Informant Ray Minsberg

(b) Address 1705 N. Pulaski St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-21-45 (month) (day) (year)

(c) Cemetery or crematory Hebrew Friendship Rm

Location

18 (a) Funeral director Jacob Levin Inc

(b) Address 1439 E. Balto St

19 (a) NOV 21 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 1-50

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-21-45 19 , at 12 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/16/45 19 , to 11/20 19 45.

and that I last saw h~~im~~ alive on 11/20 19 45.

Immediate cause of death Pulmonary edema & cardio-resp failure — Duration

Due to acute R & right sided failure

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Morris Rudo M. D.

Address Sinai Hosp Date signed 11/21/45

G34538

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 48a

Registered No. G34538

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkins & Caton Aves
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town Manchester
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Bertha Rupp

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	white	widowed

6 (b) Name of husband or wife George Rupp
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 16, 1887

8. AGE: Years	Months	Days	If less than one day
58	10	4	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business Sewing Factory

FATHER
12. Name William Setter
13. Birthplace Maryland

MOTHER
14. Maiden Name Martha M Cryder
15. Birthplace Maryland

16 (a) Informant daughter Evelyn Harris
(b) Address Homestead Maryland

17 (a) Burial (b) Date thereof Nov 23 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Manchester
Location Manchester, Md.

18 (a) Funeral director Jacob Winebrenner
(b) Address Manchester, Md.

NOV 21 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/20 1945, at 5: P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/5 1945 to 11/20 1945.
and that I last saw h.e alive on 11/20 1945.

Immediate cause of death Generalized Carcinomatosis — Duration

Due to CA CERVIX

Due to

Other Conditions Anemia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Norton Frotz
Address St Agnes Date signed 11/20/45
M.D.

VS 150

634339
483798

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registration No. 634339

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 910 N. Wurham St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leo Brooks.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Black. | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Annie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-24-05

8. AGE: Years 40 | Months - | Days 27 | If less than one day hr. min.

9. Birthplace N. C. (Town, county, and state)

10. Usual Occupation Laborer.

11. Industry or business

FATHER
12. Name Richard Brooks
13. Birthplace S. C.

MOTHER
14. Maiden Name Estelle
15. Birthplace S. C.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 23/45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location Baltimore County Md.

18 (a) Funeral director Mrs Robert G Elliott Dept
(b) Address 1129 N. Caroline St.

19 (a) Date rec'd by local reg. NOV 21 1945 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 20 1945, at 4:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 17 1945, to Nov. 20 1945, and that I last saw him alive on Nov. 20 1945.

Immediate cause of death	Duration
cardiac failure	
Due to myocarditis	
Due to unknown etiology	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John A. Green, M.D.
Address Johns Hopkins Hospital Date signed 11/20/45

TYPE OR WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34340

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓61

G34340 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1529 - N. Stricker St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Nannie Smith

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	Married

6 (b) Name of husband or wife Jesse Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-14-01.

8. AGE: Years	Months	Days	If less than one day
44	4	6	hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER — 12. Name John Bennett
13. Birthplace Va.

MOTHER — 14. Maiden Name Hannah Scruggs.
15. Birthplace ?

16 (a) Informant Evelina Smallwood
(b) Address 15[illegible] N. Stricker St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/23/45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md.

18 (a) Funeral director Reg. H. Kelson
(b) Address 1398 Pressman St.

NOV 21 1945 (Date rec'd by registrar)

19 (a) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-20 1945 at 6.05 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-16 1945 to 11-20 1945, and that I last saw h[illegible] alive on 11-20 1945.

	Duration
Immediate cause of death Respiratory failure; Hyperpyrexia	
due to Due to Cerebral embolism	
Due to Hypertensive cardiov. disease	
Other Conditions Auricular fibrillation Diabetes mellitus	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William J. Dixon
Address Johns Hopkins Hospital Date signed 11/21/45

93D

M. D. R. 1268-9

HEALTH DEPARTMENT—CITY OF BALTIMORE

G34341 CERTIFICATE OF DEATH ✓108 G34341

1. PLACE OF DEATH

Registered No.....

CITY OF BALTIMORE: (No. 1648 N. Gilmor St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Charles Butler

(a) Residence: No. 1648 N. Gilmor St., 15-1 Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
male	Col	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, year) Apr. 6, 1911

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
34	34	7	14	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Laborer

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Baltimore, Md.

FATHER

13. NAME George Butler

14. BIRTHPLACE (city or town) (State or country) Maryland

MOTHER

15. MAIDEN NAME Georgianna Johnson

16. BIRTHPLACE (city or town) (State or country) Maryland

17. INFORMANT Georgianna Butler

(Address) 1648 N. Gilmor St

18. BURIAL, CREMATION, OR REMOVAL

Place L'Hotes Date 11/23/45 19

19. UNDERTAKER Geo. L. Kelson

(Address) 1303 Pennsylvania Ave

20. FILED NOV 21 1945 Huntington Williams M.D.
Registrar

MEDICAL CERTIFICATE OF DEATH ✓

21. DATE OF DEATH (month, day, year) Nov. 20, 1945

22. I HEREBY CERTIFY, That I attended deceased from Nov. 18, 1945, to Nov. 20, 1945

I last saw him alive on Nov. 20, 1945. Death is said to have occurred on the date stated above, at 11 A.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Lobar Pneumonia	5 days

Other contributory causes of importance:

Name of operation..... Date of.....

What test confirmed diagnosis? Clinical Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide?..... Date of injury....., 19.....

Where did injury occur?.....
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.....

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?
No If so, specify.....

(Signed) Mitchell Bando, M. D.

(Address) 2445 Druid Hill Ave

V. S. 9

OCCUPATION is very important. See instructions

BURIAL CERTIFICATE OR PERMIT will not be granted if this form is not properly executed. Exact statement of

G34342

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G34342 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) Bd.
(e) Length of stay in Baltimore (yrs., mos., or days) 16 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 3 (If outside city or town limits, write RURAL and give town)
(d) Street No. 502 S. Paca St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Helena Ealise Burris

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 4 - 1945

8. AGE: Years 0 | Months 0 | Days 16 | If less than one day hr. min.

9. Birthplace Balto - 3 Md. (Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name Bingo Kenneth Burris
13. Birthplace Balto Md.

MOTHER
14. Maiden Name Ealise Martin
15. Birthplace Balto. Md.

16 (a) Informant Ealise Burris
(b) Address 502 S. Paca St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 21-45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location
18 (a) Funeral director Robt C. B. M. Walter
(b) Address Robert J. Stricker Co.
NOV 21 1945 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/20 1945, at 6:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/20 1945 to 11/20 1945; and that I last saw her alive on 11/20 1945.

Immediate cause of death Resp. Failure — Duration

Due to Dehydration & malnutrition

Due to Prematurity

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward Shaheen M. D.
Address Mercy Hosp Date signed 11/21/45

VS 150

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634343

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

634343 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1355 N. 41st Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13-8
(e) Length of stay in Baltimore (yrs., mos., or days) 40 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1355 N. 41st Street (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Grover Shenton

3 (b) If veteran, name war —
3 (c) Social Security Account No. 216-03-2658

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lavinia T. Shenton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 30-1887

8. AGE: Years 58 | Months 5 | Days 20 | If less than one day: hr. min.

9. Birthplace Dorchester Co. Maryland (Town, county, and state)
10. Usual Occupation Supervisor
11. Industry or business American Can Co.

FATHER
12. Name Raymond Shenton
13. Birthplace Maryland

MOTHER
14. Maiden Name Coral L. Billingham
15. Birthplace Maryland

16 (a) Informant Mrs. Lavinia T. Shenton
(b) Address 1355 N. 41st Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 23-1945 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) NOV 21 1945 (b) Huntington Williams M.D. 4037 Falls Rd.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 20 1945, at 3 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 20 1945 to Nov. 20 1945 and that I last saw him alive on Nov. 20 1945.

Immediate cause of death: Ventricular Fibrillation — Duration: 5-6 Hrs.
Due to: Coronary Thrombosis
Due to: Coronary Artery Disease
Other Conditions: Hypertension
C-V. Disease
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Edward L. Glassman M. D.
Date signed 11/20/45

VS 150

HEP #88020 G34344

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1/3 B

Registered No. G34344

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1- 6- & 4 26-9
(e) Length of stay in Baltimore (yrs., mos., or days) 55-8 & 18

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 807 S. Fagley St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Fischer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary Fischer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 1, 1890

8. AGE: Years	Months	Days	If less than one day
55	8	18	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Night Watchman
11. Industry or business Unemployed

FATHER
12. Name Frank Fischer
13. Birthplace Md.

MOTHER
14. Maiden Name Anne Gebhardt
15. Birthplace Md.

16 (a) Informant Balto. City Hospitals Records
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof 11/23/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Laurel Heights
Location German Hill Rd.
18 (a) Funeral director Lilly & Zeh
(b) Address 403 S. Bond St

19. 11 21 1945 (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 19, 1945, at 5:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 15, 1944 to Nov. 19, 1945, and that I last saw him alive on Nov., 19, 1945.

Immediate cause of death Pulmonary Tuberculosis
Due to Tuberculous Enteritis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: No Post

Duration: 2

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert F. Copeland Jr. M. D.
Address Balt. City Hosp. Date signed 11/20/45

Huntington Williams, M.D.

X

Please write plainly, with UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34345 — BALTIMORE CITY HEALTH DEPARTMENT — G34345 Registered No.

CERTIFICATE OF DEATH 83a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2403 Lauretta Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2403 Lauretta Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** William Schaltz Sen.

3 (b) If veteran, name war	3 (c) Social Security Account No.
✓	✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	widower

6 (b) Name of husband or wife Mary A. Schaltz Sen.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 16, 1865

8. AGE: Years	Months	Days	If less than one day
80	9	3	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Anthony Schaltz Sen.
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Marie Meising
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Bertha E. Harris
(b) Address 2403 Lauretta Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 22 45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location U.S. Frederick Road

18 (a) Funeral director Krauss Funeral Home
(b) Address 216 N. Charles St.

19 (a) (Signature of undertaker) (b) Huntington Williams, M.D.

NOV 21 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/19 1945, at 10:20 A.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 11/10 1945 to 11/19 1945 and that I last saw him alive on 11/18 1945

Immediate cause of death: Cerebral Hemorrhage

	Duration
Due to: Hypertension	1 week
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas A. Cohn M.D.
Address 2145 W. Biddle Date signed 11/20/45

X

G34346

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G34346 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3330 Virginia Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-16
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3330 Virginia Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME IDA J. LEVIN

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife Chas. Woodrow Levin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jany 7. 1877

8. AGE: Years 68 | Months 10 | Days 13 | If less than one day hr. min.

9. Birthplace Phila. Pa.
(Town, county, and state)

10. Usual Occupation —
11. Industry or business

FATHER
12. Name Jos. Hilson
13. Birthplace Phila

MOTHER
14. Maiden Name Sarah Eastman
15. Birthplace Boston

16 (a) Informant Chas. J. Levin
(b) Address 3330 Virginia Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 22/37 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemy.
Location Baltimore, Md.

18 (a) Funeral director John O. Mitchell
(b) Address 1906 Eutaw Place

19 (a) (Date rec'd by registrar) (b) Washington for Nathaniel, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 | 20 | 37 19 at 11:37 PM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis M.D.
Medical Examiner.
Date signed 11 | 21 | 37

X

G34347

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 42a

G34347 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital 27-20
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hours
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3413 Devonshire Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** John MacEachern

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 23 - 1903

8. AGE: Years	Months	Days	If less than one day
42	4	27th	hr. min.

9. Birthplace Colorado Springs Colorado (Town, county, and state)

10. Usual Occupation Bookkeeper

11. Industry or business Sanitary Laundry

FATHER
12. Name James MacEachern
13. Birthplace Cape Britton N.S.

MOTHER
14. Maiden Name Ellen Rossignol
15. Birthplace St John N.B.

16 (a) Informant Ethelyn Mae Eachern
(b) Address 3413 Devonshire Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 21-45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto Md

18 (a) Funeral director Ellsworth Armagost
(b) Address 3911 Liberty Heights Ave

19 (a) Nov 21 1945 (Date rec'd by registrar) (b) Huntingtown Millwaukie, Md Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-19 1945, at 2:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-19 1945 to 11-19 1945, and that I last saw h alive on 11-19 1945

Immediate cause of death	Duration
Rheumatic Heart Disease Card dil + Hyp., mitral insuff + sten., Aortic insuff + sten.	24 yrs.
Due to Auricular fibrilation Chronic cong. failure	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: see above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Gerald Katz M. D.
Address Sinai Hosp Date signed 11-19-45
Balt. Md

VS 100

G34348

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G34348 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3424 St. Ambrose Ave., 2nd 18
(c) Hospital or institution:
(Died at the home of a Relative)
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 dys.
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3304 Woodland Ave.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Matie Odell Harper,

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife T. Dennis Harper,
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 29,1856

8. AGE: Years	Months	Days	If less than one day
89	4	21	hr. min.

9. Birthplace Georgetown, D. C.
(Town, county, and state)
10. Usual Occupation Housewife,
11. Industry or business at home

FATHER
12. Name Louis Odell,
13. Birthplace Georgetown, D. C.

MOTHER
14. Maiden Name Leisheur,
15. Birthplace Georgetown, D. C.

16 (a) Informant Miss S. Louise Harper,
(b) Address 3304 Woodland Ave.,

17 (a) Burial (b) Date thereof 11/23/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Baltimore Co., Md.

18 (a) Funeral director C. Vernon Lemmon.
(b) Address 4611 Park Heights Ave.,

Nov 21 1945 (b) Huntington Williams, M.D.
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 20, 1945 19 , at 5 - A. M

21. I certify that death occurred on the date above stated; that I attended deceased from hw 1942; to Nov. 20 1945, and that I last saw h er alive on Nov. 18 1945

Immediate cause of death	Duration
Myocarditis.	24 yrs.
Due to Hypertension	3 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. L. DeBarbieri M. D.
Address 4723 Park Heights Date signed

X

...ry item or information should be carefully supplied. The ...e the causes of death clearly and legibly.
...age is especially important. Physicians: please write the

G34349 BALTIMORE CITY HEALTH DEPARTMENT G34349

CERTIFICATE OF DEATH 50

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3424 St. Ambrose Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 16
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 3424 St. Ambrose Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary H. ~~Harper~~, YATES

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single,

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 30, 1885

8. AGE: Years	Months	Days	If less than one day
60	2	19	hr. min.

9. Birthplace Washington D. C. (Town, county, and state)
10. Usual Occupation OPERATOR
11. Industry or business TELEPHONE Co.

FATHER
12. Name Richard H. Yates,
13. Birthplace Washington, D. C.

MOTHER
14. Maiden Name Mary Harper,
15. Birthplace Washington, D. C.

16 (a) Informant William F. Yates,
(b) Address 3424 St. Ambrose Ave.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/23/45 (month) (day) (year)
(c) Cemetery or crematory Holy Rood Cemetery
Location Washington, D. C.

18 (a) Funeral director Le Vernon Lemmon.
(b) Address 4611 Park Heights Ave.,

NOV 23 1945 (c) Registrar Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 19, 1945 19 at 1130 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1944 to Nov. 1945, and that I last saw her alive on Nov. 19 45

Immediate cause of death	Duration
Malignancy of Breast	2 yrs
Due to Pulmonary metastasis	1 year
Due to Effusion	1 year
Other Conditions Heart Failure	5 days

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Alex A Weinstock M. D.
Address 4603 Park Heights Date signed

VS 150

G34350

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

10

G34350 Registered No.

Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Hanford Rd & Hemming Ave
(c) Hospital or institution:
Sydenham Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town 1802 E. Pratt St
(If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Betty Stevens

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-25-27

8. AGE: Years	Months	Days	If less than one day
18	8	27	hr. min.

9. Birthplace Clarksburg, W. Va.
(Town, county, and state)

10. Usual Occupation School

11. Industry or business —

FATHER
12. Name Ola Herbert Stevens
13. Birthplace Fairmont, W. Va

MOTHER
14. Maiden Name Zora Ellen Oldaker
15. Birthplace Gilbert Co W. Va

16 (a) Informant Father
(b) Address above

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof NOV. 23, 45 (month) (day) (year)

(c) Cemetery or crematory
Location Clarksburg W. Va.

18 (a) Funeral director L. HEEMANN & SON
(b) Address 32 S. Broadway

(a) (Local registrar) (b) Huntington, W. Va.

NOV 21 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-21 1945, at 5:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-18 1945 to 11-21 1945, and that I last saw h[er] alive on 11-21 1945.

Immediate cause of death	Duration
Diph. Carrig. & myocarditis & cerebral Anemia	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 11-18-45

Major findings of operation: Tracheotomy

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John B. Jones M.D.

Address Sydenham Hosp Date signed 11/21/45

X

G34351

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G34351 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2606 Uhlman Ave
(c) Hospital or institution:
?
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 D
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2606 Uhlman Ave
(If rural give location)
(e) Citizen of foreign country? Uhlman (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Frushour

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Stella Frushour

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 22, 1883

8. AGE: Years 62 | Months 8 | Days 29 | If less than one day ____ hr. ____ min.

9. Birthplace Walkersville, Md.
(Town, county, and state)

10. Usual Occupation Auto machinist

11. Industry or business

FATHER
12. Name Robert Frushour
13. Birthplace Lewistown, Md.

MOTHER
14. Maiden Name Jennie Shouffer
15. Birthplace Md.

16 (a) Informant Mrs. Mary V. Thrift
(b) Address 614 Gallatin St. D.C.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Nov 24 1945 (month) (day) (year)

(c) Cemetery or crematory
Location Washington, D.C.

18 (a) Funeral director James T. Ryan Jr.
(b) Address 317 Penn Ave. N.W. Washington, D.C.

NOV 22 1945 (Registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 21 1945, at 10:00 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis,

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Grattan M.D.
Medical Examiner.
Date signed Nov. 21 1945

Please write the causes of death clearly and legibly. Physicians: please write age is especially important.

G34352 BALTIMORE CITY HEALTH DEPARTMENT G34352

CERTIFICATE OF DEATH 163H

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3-0
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County (Boarder)
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 417 W. Saratoga St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John A. Carney

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 11-1910

8. AGE: Years 35 | Months 10 | Days 8 | If less than one day hr. min.

9. Birthplace N. J.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Morris Carney
13. Birthplace N. J.

MOTHER
14. Maiden Name Loretta Creevy
15. Birthplace N. J.

16 (a) Informant John E. Day
(b) Address N. J.

17 (a) Removal (b) Date thereof 11/22/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Red Bank.
Location New Jersey

18 (a) Funeral director Wm B Cook Inc
(b) Address 1217 S. Eutaw St

NOV 22 1945 (Registered by) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-19- 1945 at 10-25 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation

Due to Illuminating Gas

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-19- at a. M.
(b) Where did injury occur? 417 W. Saratoga St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Kitchen gas range unlit jets

23. Signature Howard J. Mikkelsen M.D.
Medical Examiner.
Date signed 11-19-45

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34353

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92B

G34353 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution:
Maryland General Hospital 9-7
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County City Balto
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1520 Abbottston Sto
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Jane Arnett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 18 - 1936

8. AGE: Years	Months	Days	If less than one day
9	5 6	12 2	hr. min.

9. Birthplace Pennsylvania
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Harry W. Arnett
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Margaret R. Willson
15. Birthplace Baltimore

16 (a) Informant Mrs M R Arnett
(b) Address 1520 Abbottson Street

17 (a) Burial (b) Date thereof Nov 22/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Parkwood
Location Parkville Md.

18 (a) Funeral director William Cook Jno
(b) Address 212 St Paul St Balto Md

19 (a) Filed Nov 23 1945 (b) Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 20 1945, at 2:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from November 19 1945, to Nov 20 1945, and that I last saw h[illegible] alive on November 19 1945.

Immediate cause of death	Duration
Cardiac failure	
Due to Mitral stenosis & insufficiency	
Due to Rheumatic fever	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. M. Caudill M. D.

Address Maryland General Hosp Date signed 11-20-45

X

G34354
483535

BALTIMORE CITY HEALTH DEPARTMENT XV G34354
Registered No.

CERTIFICATE OF DEATH 131a

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Michigan (b) County
(c) City or town Grosse Pt. Farms (If outside city or town limits, write RURAL and give town)
(d) Street No. 209 Lakeshore Road. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John W. Anderson.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Gustave
6 (c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) 9-25-67

8. AGE: Years	Months	Days	If less than one day
78	1	26	hr. min.

9. Birthplace Wisconsin (Town, county, and state)
10. Usual Occupation Lawyer
11. Industry or business

FATHER
12. Name Wendell A. Anderson
13. Birthplace Maine

MOTHER
14. Maiden Name Susan M. Ewall
15. Birthplace Maine

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11/22/45 (month) (day) (year)
(c) Cemetery or crematory
Location Detroit, Mich
18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address North & Pine Aves.

22 1945 (Date filed by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 21 1945, at 6 45 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 12 1945 to Nov. 21 1945 and that I last saw him alive on Nov. 21 1945.

Immediate cause of death	Duration
Cardiac Failure	
Due to Hypertensive Cardio-Vascular Disease	?6 yrs
Due to	
Other Conditions Azotemia & Nephritis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Laurence Dickson M.D.
Address Johns Hopkins Hospital Date signed 11/24/45

VS 150

G34355

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G34355

927

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4300 Belvieu Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4300 Belvieu Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES WILLIAM REINHARDT

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Charlotte Reinhardt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 9, 1878

8. AGE: Years	Months	Days	If less than one day
67	5	11	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation Owner -
11. Industry or business Bakery

FATHER
12. Name Christian Reinhardt
13. Birthplace Germany

MOTHER
14. Maiden Name Wilhelmina Stoll
15. Birthplace Germany

16 (a) Informant Mrs. Charlotte Reinhardt
(b) Address 4300 Belvieu Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/23/45 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Filed by registrar Washington Williams, M.D. Registrar

MEDICAL CERTIFICATION

P

20. DATE OF DEATH Nov. 20, 1945 at 1:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-1-1944 to 11-20 1945 and that I last saw h[illegible] alive on 11-20-1945

Immediate cause of death — Duration

Myocardial Fantures - 10 days
Due to Cardiac Hypertrophy 2 yr
Due to Acute Coronary Heart 2 yr

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harvey F. [illegible] M. D.
Address 2604 Garrison Blvd Date signed 11-21-45

(16)

VS 150

G34356 G34356

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 93D

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 205 E. 32nd St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County V
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 205 E. 32nd St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Caroline Marshall Wittig

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
None	None	F	W.	Married

6 (b) Name of husband or wife Wm. Geo. Wittig, Sr. 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 29, 1872

8. AGE: Years	Months	Days	If less than one day
73	3	20	hr. min.

9. Birthplace Queen Anne Co., Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name James Marshall
13. Birthplace Md.

MOTHER
14. Maiden Name --
15. Birthplace Md.

16 (a) Informant Mr. Wm. G. Wittig
(b) Address 205 E. 32d St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/23/45 (month) (day) (year)
(c) Cemetery or crematory Greenmount Mausoleum
Location Baltimore, Md

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) 1945 (Date rec'd by registrar) (b) Thurlington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 19 1945, at 11:30 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to Arteriosclerotic cardiovascular disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. Faehner M.D. Medical Examiner.
Date signed Nov. 19 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34357 BALTIMORE CITY HEALTH DEPARTMENT G34357

CERTIFICATE OF DEATH 97 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline Ave.
(c) Hospital or institution: St. Joseph's Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Little Sisters of the Poor (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anna Annie Sanders
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. M.W.

6 (b) Name of husband or wife John Snyder
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 17, 1863

8. AGE: Years 82 | Months 1 | Days 3 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Albert Miller
13. Birthplace Germany

MOTHER 14. Maiden Name Eliz. Steinfeld
15. Birthplace Germany

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 23, 1945 (month) (day) (year)
(c) Cemetery or crematory St. Stevens
Location Balto Co.

18 (a) Funeral director Rita Wiedefeld
(b) Address 914 Greenmount Ave

19 (a) 11-24-1945 (Date rec'd by registrar) (b) Harrington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-20-45 19 ..., at 12:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/6/45 19 ..., to 11/20/45 19 ..., and that I last saw h[illegible] alive on 11/20/45 19 ...

Immediate cause of death Cardiac asphyxiation, failure

Due to Generalized arteriosclerosis

Due to

Other Conditions Cystoscopic examination

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations Negative

of autopsy

Duration

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Hyman Lemonick M. D.
Address St. Joseph's Hosp. Date signed 11/20/45

G34358

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G34358 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline St.
(c) Hospital or institution: St. Joseph's Hosp. 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 904 E. Biddle St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Captain John Welby

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	Married.

6 (b) Name of husband or wife Margaret
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 4, 1890

8. AGE: Years	Months	Days	If less than one day
55	2	17	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Fire Department
11. Industry or business Baltimore City

FATHER
12. Name John A. Welby
13. Birthplace Ireland

MOTHER
14. Maiden Name Annie Butler
15. Birthplace Ireland

16 (a) Informant Mrs. Margaret T. Welby
(b) Address 703 Indra St.

17 (a) Burial (b) Date thereof Nov. 24/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mount Cathedral Cem.
Location 4300 Old Frederick Rd.

18 (a) Funeral director Elmer W. Conklin Son
Address 924 E. Eager St.

19 (a) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

NOV 22 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-21 1945 at 6 45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-7 1945 to 11-21 1945 and that I last saw him alive on 11-20 1945.

Immediate cause of death Cardiac failure — Duration

Due to Auricular fibrillation

Due to Coronary Occlusion.

Other Conditions Pulmonary Infarction.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm H Frank M. D.
Address St. H. Jos. Hosp. Date signed 11-21-45

X

VS 150

THE ENTRIES MADE HEREIN, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34359
477968

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 48a

G34359
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6404 Belton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Florence Barry

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-26-93

8. AGE: Years 51 | Months 11 | Days 25 | If less than one day hr. min.

9. Birthplace Pa.
(Town, county, and state)

10. Usual Occupation Home-wife

11. Industry or business

FATHER
12. Name Wm Beggs
13. Birthplace Pa.

MOTHER
14. Maiden Name Charlotte Kavanaugh.
15. Birthplace Pa

16 (a) Informant Rhonda
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Nov 24/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mount Cathedral Cemetery
Location 4300 Old Frederick Rd

18 (a) Funeral director Elmer W. Cookham & Son
(b) Address 924 E. Eager St

19 (c) NOV 22 1945
(Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 21 1945, at 5:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 29 1945, to Nov. 21 1945, and that I last saw h[er] alive on Nov. 21 1945.

Immediate cause of death: Carcinoma uteri - Lobe III - treated -
Duration: 7 Months

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Russell Jordan M. D.
Address 805 N. Broadway Date signed 11-21-45

VS 150

THIS WHITE COPY, WITH UNFADING INK, EXACTLY DUPLICATES THE ORIGINAL. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3 Index
G34360

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1213

G34360
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Payson St
(c) Hospital or institution:
Bon Secours
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 7 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 705 Dryden Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mr. John Cornelius Kistler

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Lynne A. Isaacson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/13/1899

8. AGE: Years 46 | Months 0 | Days 7 | If less than one day hr. min.

9. Birthplace La Porte Indiana
(Town, county, and state)

10. Usual Occupation Chemist

11. Industry or business Schenley-Kinsale Co.

FATHER
12. Name George Kistler
13. Birthplace Indiana

MOTHER
14. Maiden Name —
15. Birthplace Indiana

16 (a) Informant Mrs. Lynne A. Kistler
(b) Address 705 Dryden Ave

17 (a) ~~Burial~~ Removal (b) Date thereof 11/22/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location La Porte Indiana

18 (a) Funeral director Harry A. Witzke
(b) Address 4101 Edmondson Ave

19 (a) 22 1945 (b) Huntington Williams M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 | 20 | 1945, at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11 | 16 | 1945 to 11 | 20 | 1945 and that I last saw him alive on 11 | 19 | 1945

Immediate cause of death Congestive Heart Failure — Duration —
Due to Rheumatic Cardio-Vascular Disease 2 Mitral Stenosis — 3 days
Due to Bronchial Asthma —
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Chas Norton, Jr. M.D.
Address Bon Secours Hosp. Date signed 11/20/45

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

✓ G34361

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓94a

G34361
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 808 N. Augusta Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 808 N. Augusta Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROBERT W. HARPER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife May Turner Harper
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 22, 1888.

8. AGE: Years	Months	Days	If less than one day
57	2	27	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Guard
11. Industry or business Doughnut Corp.

FATHER
12. Name Robert W. Harper
13. Birthplace Maryland

MOTHER
14. Maiden Name Fannie Wallace
15. Birthplace Maryland

16 (a) Informant Mrs. May T. Harper
(b) Address 808 N. Augusta Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 23,1945 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cemetery
Location Pikesville, Maryland

18 (a) Funeral director Harry A. Luitje
(b) Address 4101 Edmondson Avenue

1945 (Date rec'd by registrar) (b) Registrar

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 19, 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 13, 1945 to Nov. 19, 1945, and that I last saw him alive on Nov. 18, 1945

Immediate cause of death	Duration
Coronary Thrombosis	
Due to Acute Bronchitis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leonard Kenup M.D.
Address 3030 Edmondson Ave. Date signed 11/20/45

VS 150

×

G34368 BALTIMORE CITY HEALTH DEPARTMENT G34368
CERTIFICATE OF DEATH 937 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3927 Greenmount Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3927 Greenmount Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anthony A Bergler

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) ~~Single~~, ~~married~~, widowed, or ~~divorced~~. Widow

6 (b) Name of husband or ~~wife~~ Annie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 15 1867

8. AGE: Years 78 | Months 3 | Days 5 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business Carpenter

FATHER
12. Name Conrad Berger
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret ?
15. Birthplace Germany

16 (a) Informant Conrad A Berger
(b) Address 3927 Greenmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 23 1945 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Dolph C Mosan
(b) Address 3000 E Baltimore St

19 (a) (Date rec'd by registrar) Huntington Williams, M.D.
NOV 22 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 20 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from March 6, 1945 to Nov. 19, 1945 and that I last saw h~~im~~ alive on Nov 19, 1945.

Immediate cause of death Coronary occulsion. — Duration Sudden

Due to Chronic myocarditis — ?

Due to Osteriosclerosis — ?

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Willis Guyton
Address 3963 Greenmount Ave Date signed M. 7 D. 21 1945

X

G34363 BALTIMORE CITY HEALTH DEPARTMENT G34363

CERTIFICATE OF DEATH 77c

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age in all cases.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 wks
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2026 Maryland Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Earl H. Keefer

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-05-2833

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 8, 1900

8. AGE: Years	Months	Days	If less than one day
45	2	14	hr. min.

9. Birthplace Indian Springs Wash. Md.
(Town, county, and state)

10. Usual Occupation Painter

11. Industry or business Self Employed

FATHER
12. Name Elisha J Keefer
13. Birthplace Big Pool Md.

MOTHER
14. Maiden Name Bessie E Drury
15. Birthplace Dry Run Pa

16 (a) Informant Mrs Robert Folty
(b) Address W. Wash. St Hag. Md.

17 (a) Burial (b) Date thereof Nov 24 (94)
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Rose Hill
Location Hagerstown Md

18 (a) Funeral director Stott & Mumma
(b) Address Hagerstown Md

19 (a) NOV 23 1945 (Date received by registrar) Huntington Mumma, Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 22 1945, at 8 30 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Glomerulitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Guthrie M.D.
Medical Examiner.
Date signed Nov. 22 1945

G34364

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

166

G34364 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hosp. 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 826 Edmondson Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Raymond Wright

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Married

6 (b) Name of husband or wife Annie Bell Wright
6 (c) If alive, give age 1 years

7. Birth date of deceased (mo., day, yr.) 1907

8. AGE: Years	Months	Days	If less than one day
38			hr. min.

9. Birthplace Durham N. C. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mary Washington
(b) Address 826 Edmondson Ave.

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof Nov. 23 45 (month) (day) (year)
(c) Cemetery or crematory
Location Durham, N. C.

18 (a) Funeral director Mrs. Hattie R. Williams
(b) Address 322 N. Schroeder St

19 (a) (b) Huntington Williams Registrar

NOV 23 1945
VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 19 1945, at 6 30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Stab Wounds of Arm

Due to

Other Conditions Bullet Wound of Neck

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Nov. 19 1945 at 5 30 P.M.
(b) Where did injury occur? 1100 Pennsylvania Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Tavern While at work? No
(d) Means of injury Stabbed & Shot

23. Signature Raymond Lee Yeakel M.D. Medical Examiner.
Date signed Nov. 21 1945

X

G34365

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G34365

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3[illegible]
(c) Hospital or institution: Johns Hopkins Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 9 Albemarle Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Martin Noone

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 14 1904

8. AGE: Years	Months	Days	If less than one day
41	8	7	hr. min.

9. Birthplace Penna (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Patrick Noone
13. Birthplace Penna

MOTHER
14. Maiden Name Catherine Tamer
15. Birthplace Penna

16 (a) Informant Michael Noone
(b) Address Delano Penna

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11-22-45 (month) (day) (year)
(c) Cemetery or crematory
Location Mahanoy City Penna

18 (a) Funeral director Boyle & Farley
(b) Address Fulton & Fayette

19 (a) NOV 23 1945 (Date rec'd by registrar) Huntington Williams, MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 21, 1945 at 10 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions Generalized arteriosclerosis, chr. myocarditis, mural thrombus & dilatation
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mercer M.D. Medical Examiner.
Date signed 11-21-45

VS 151

Please write the causes of death clearly and legibly. Physicians: Correct age is especially important.

G34366 BALTIMORE CITY HEALTH DEPARTMENT G34366

CERTIFICATE OF DEATH

Registered No. 46 B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: U.S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 72 days
(e) Length of stay in Baltimore (yrs., mos., or days): 72 days

2. USUAL RESIDENCE OF DECEASED:
(a) State: Ga. (b) County:
(c) City or town: Thomson (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country:

3 (a) **FULL NAME**: Shields, Roy Eramus

3 (b) If veteran, name war:
3 (c) Social Security Account No. 156-16-1663

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	single

6 (b) Name of husband or wife:
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 4, 1890

8. AGE: Years	Months	Days	If less than one day
55	-	15	hr. min.

9. Birthplace: Thomson, Ga. (Town, county, and state)
10. Usual Occupation: chief cook
11. Industry or business: seafarer

FATHER
12. Name: Willie Shields
13. Birthplace: Ga.

MOTHER
14. Maiden Name: Bessie Sheiber
15. Birthplace: SC

16 (a) Informant: Records
(b) Address: US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 23. 45 (month) (day) (year)
(c) Cemetery or crematory: Greene Progressive Cem.
Location: York Rd.

18 (a) Funeral director: O'Donnell Funeral Home Inc.
(b) Address: 4644 York Rd.

19 (a) [illegible] NOV 23 1945 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 19 1945, at 2:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 8 1945 to Nov. 19 1945, and that I last saw him alive on Nov. 19 1945.

Immediate cause of death	Duration
Metastatic adenocarcinoma of liver (primary stomach resected	Unknown
Due to March 1945)	
Due to Pneumonia lobular terminal	several days
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: C.I. Johnson C.I. Johnson, PA Surgeon
Address: U.S. Marine Hospital, Baltimore, Md. Date signed: 11/21/45

G34367

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 B

Registered No. G34367

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write to the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N. Broadway
(c) Hospital or institution: Church Home & Hospital 5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 days
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1208 East Baltimore (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country Russia

3 (a) FULL NAME Rubin, Mrs Bessie / Bessie Rubin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widow

6 (b) Name of husband or wife Late Jacob
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) about 1873

8. AGE: Years	Months	Days	If less than one day
72			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Saul Levin
13. Birthplace Russia

MOTHER
14. Maiden Name Not known (Annie Levin)
15. Birthplace Russia

16 (a) Informant Sam A. Goldstein
(b) Address 3436 Piedmont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 23/45 (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cemetery
Location Hamilton ave

18 (a) Funeral director Sol Feinman Bur
(b) Address 1124-26 W North ave

(a) Date received by registrar NOV 23 1945 (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 - 22 1945 at 50 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10 - 28 1945 to 11 - 22 1945 and that I last saw her alive on 11 - 22 1945

Immediate cause of death Pulmonary Edema

Duration 48 hrs

Due to Acute Cardiac decompensation 48 hrs.

Due to Arteriosclerotic Heart disease

Other Conditions Gastrectomy, Cervical esophageal fistula

(Include pregnancy within 3 months of death)

Date of operation 11-14-45

Major findings of operation: Carcinoma of stomach & esophagus, Adeno Carcinoma

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ben Bohnen M. D.

Address Church Home & Hosp. Date signed 11-22-45

VS 150

634368

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 17 c

✓ 634368 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27 12
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 411 Lockland Avenue (If rural give location) 411 Frankland Ave
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William S. Frishgaugh

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	

6 (b) Name of husband or wife Agnes

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years	Months	Days	If less than one day
71			hr. min.

9. Birthplace Balto Co. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name E. Frishgaugh
13. Birthplace Balto Co.

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant John Frishgaugh
(b) Address 2305 Rott St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-24-45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Baltimore Co. Md.

18 (a) Funeral director John A. Noran
(b) Address 500 E. Balto St

19 (a) (Date rec'd by registrar) (b) Registrar
NOV 23 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 20 1945, at 9 50 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Contusion of brain
Intracranial hemorrhage
Due to

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-20-45 at 4:45 A.M.
(b) Where did injury occur York & Jarrettsville Rds
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? —
(d) Means of injury Struck by auto while attempting to get from streetcar

23. Signature Benedict Mitarelis M.D. Medical Examiner.
Date signed 11-21-45

Please write the causes of death clearly and legibly. Physicians: please write the cause of death clearly and legibly.

G34369

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G34369

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1646 Cliftview Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1646 Cliftview Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Crowley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Joseph
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 13 1879

8. AGE: Years	Months	Days	If less than one day
66	4	6	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation None
11. Industry or business

FATHER
12. Name Julius Stanpt
13. Birthplace Germany

MOTHER
14. Maiden Name Selma
15. Birthplace Germany

16 (a) Informant Selma Simon
(b) Address 1646 Cliftview Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 23 1945 (month) (day) (year)
(c) Cemetery or crematory Baltimore Lan
Location E. North Ave

18 (a) Funeral director John A Mosan
(b) Address 3000 E Baltimore

19 (a) (b) Date received NOV 23 1945 Williams Registrar

Hunting for

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 19 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 18 1945, to Nov 19 1945, and that I last saw her alive on Nov 19 1945.

Immediate cause of death Bronchopneumonia — Duration 2 days

Due to

Due to

Other Conditions Hypertensive Cardio Vascular Renal Disease

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

Signature Thomas E Woolfe M.D.

Address 1331 E North Ave Date signed 11-22-45

107

G34370

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G34370

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1626 St. Paul St
(c) Hospital or institution:
12-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1626 St. Paul St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Von Harten

3 (b) If veteran, name war: No

3 (c) Social Security Account No.: No

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: George Von Harten

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 15 1858

8. AGE: Years 87 | Months 3 | Days 6 | If less than one day hr. min.

9. Birthplace Balto
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Louis Kuhn
13. Birthplace Lorch Germany

MOTHER
14. Maiden Name Elizabeth Dettmer
15. Birthplace Hanover

16 (a) Informant Miss Stella B Kuhn
(b) Address 162[illegible] St. Paul St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 26, 1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Hyperion Ave

18 (a) Funeral director H. Lander & Sons
(b) Address North Ave. & Broadway

19 (a) [illegible] NOV 23 1945 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 21 1945 at 1:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 10 1945 to Nov 21 1945, and that I last saw h[illegible] alive on Nov 20 1945.

	Duration
Immediate cause of death: Terminal Broncho-pneumonia	4 days
Due to: Myocardial failure	2 mos.
Due to: Arterio-sclerosis	6 years.
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Frederick Lentz M. D.
Address Temple Garden Apts Date signed 11-21-45

G34371

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G34371 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2057 Hough Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2057 Hough Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MAKS. KLUGA

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Stanislawa

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years	Months	Days	If less than one day
62			hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name Martin Kluga
13. Birthplace Poland

MOTHER
14. Maiden Name ?
15. Birthplace Poland

16 (a) Informant Stanislawa Kluga
(b) Address 2057 Hough St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 26 45 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Fred W. Ozarowski
(b) Address 1930 Eastern Ave.

19 (a) NOV 23 1945 (Date received by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/22/45 19 , at 7:20 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to this death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis M.D.
Medical Examiner.
Date signed 11/22/45

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34372

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

Registered No. G34372

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Washington, D.C. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1930 New Hampshire Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph Braun

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife: Mrs. Sallie Braun
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 2 1859

8. AGE: Years	Months	Days	If less than one day
86	10	18	hr. min.

9. Birthplace Charles County, Maryland (Town, county, and state)
10. Usual Occupation Cook
11. Industry or business B. & O. Railroad

FATHER
12. Name Peter Braun
13. Birthplace Maryland

MOTHER
14. Maiden Name Sarah Braun
15. Birthplace Maryland

16 (a) Informant Mrs. Sallie Braun
(b) Address 1930 New Hampshire Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-24-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Maryland

18 (a) Funeral director Charles L. Law
(b) Address 502-04 Madison Ave.

19 (a) (Date received by Registrar) NOV 23 1945 (b) Huntington Williams, M.D. Registrar

VS

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 20 1945, at 9 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 16 1945 to Nov 20 1945, and that I last saw h[illegible] alive on Nov 20 1945.

Immediate cause of death Gen'l Peritonitis
Late
Duration 2 wks

Due to rupture of ileum
Duration 2 wks

Due to distension & fecal impaction
Duration 3-4 wks

Other Conditions subdiaphragmatic abscess, multiple liver abscesses, [illegible] of duodenum
Duration over

Date of operation
Major findings of operation:
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John P Downes M.D.
Address University Hosp Date signed 11/21/45

G34373

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G34373

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 W. 40th St.,
(c) Hospital or institution: Home for Incurables
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 6 25 13-7
(e) Length of stay in Baltimore (yrs., mos., or days) 5 6 25

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 700 W. 40th St. — Home for Incurables (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ida Louisa Thompson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	White	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 14, 1861

8. AGE: Years	Months	Days	If less than one day
84	2	9	hr. min.

9. Birthplace Farmington, Maryland. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Anthony Thompson
13. Birthplace Rising Sun Md.

MOTHER
14. Maiden Name Rebecca Brickley
15. Birthplace Rising Sun, Md.

16 (a) Informant Home for Incurable Records
(b) Address 700 W. 40th St. — m. 7.10.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 26 1945 (month) (day) (year)
(c) Cemetery or crematory Roseneath
Location Near Port Deposit Md

18 (a) Funeral director J. E. Tyson
(b) Address Rising Sun Md.

NOV 23 1945 (Date rec'd by registrar) (Signature) Livingston Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 23 1945, at 12.15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from April 20 1940, to Nov. 23d 1945, and that I last saw h-r alive on Nov. 21st 1945.

Immediate cause of death	Duration
Cerebral Hemorrhage	4 [illegible]
Due to Hypertensive and Arteriosclerotic Cardiovascular Disease	10 years +
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas Conrad Wolff M. D.
Address 11 E. Chase St. Baltimore, Md. Date signed 11/23/45

VS 3

Please write the causes of death clearly and legibly. Physicians: please correct age is especially important.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34[redacted]

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

Registered No. G33[redacted]450

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5days
(e) Length of stay in Baltimore (yrs., mos., or days) 22yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1635 Lorman St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Spencer Contee

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Rosie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 26- 1890

8. AGE: Years	Months	Days	If less than one day
55	5	25	hr. min.

9. Birthplace Washington, D.C.
(Town, county, and state)
10. Usual Occupation Odd jobs
11. Industry or business

FATHER
12. Name William Contee -D-
13. Birthplace Washington, D.C.

MOTHER
14. Maiden Name Rosie ? -D-
15. Birthplace Washington, D.C.

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/24/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary.
Location A. A. Co. Md.

18 (a) Funeral director Chas. H. Alexander.
(b) Address 921. N. Monroe st.

19 (a) (b) Registrar

NOV 23 1945

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 21- 1945, at 5.30AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-16- 1945 to 11-21- 1945 and that I last saw h. in alive on 11-21- 1945.

Immediate cause of death Pulmonary Tuberculosis — Duration 2

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No Post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Herbert B. Copeland Jr. M.D.
Address Balt. City Hosp. Date signed 11/21/45

X

G34375

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. G34375

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1124 N. Gilmor St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give county)
(d) Street No. 1124 N. Gilmor St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frances Stone

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	

6 (b) Name of husband or wife Joseph Stone

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1889

8. AGE: Years	Months	Days	If less than one day
56			hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace unknown

MOTHER
14. Maiden Name — Scott
15. Birthplace Va.

16 (a) Informant Joseph Stone
(b) Address 1124 Gilmor St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/25/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A. A. Co. Md.

18 (a) Funeral director Chas. H. Alexander
(b) Address 917 Mount St.

19 (a) NOV 23 1945 (Date rec'd by registrar) (b) (Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 21, 1945, at 1:40 P. M.

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardio-vascular disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skiotarelis M.D. Medical Examiner.
Date signed November 21, 1945.

Hunting for Physician M.E.

G34576

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 a

Registered No. G34576

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2519 W. Lanvale St.
(c) Hospital or institution: 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ***
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2519 W. Lanvale St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clara G. Turfle

3 (b) If veteran, name war: ***

3 (c) Social Security Account No. none

4. Sex: Female

5. Color or race: Wht.

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Harry J. Turfle

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) Dec. 18, 1874 (1874)

8. AGE: Years 70 | Months 11 | Days 3 | If less than one day: hr. min.

9. Birthplace: Woodsboro Md.
(Town, county, and state)

10. Usual Occupation: House-wife

11. Industry or business

FATHER
12. Name: Ephriam D. Grimes
13. Birthplace: Woodsboro Md.

MOTHER
14. Maiden Name: Anglina Harris
15. Birthplace: Woodsboro Md.

16 (a) Informant: Mrs. Alice M. Byers
(b) Address: 2519 W. Lanvale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Nov. 24, 1945 (month) (day) (year)
(c) Cemetery or crematory: Mt. Hope
Location: Woodsboro Md.

18 (a) Funeral director: Robert S. Little
(b) Address: 2700 Edmondson Ave.

19 (a) (Date received by Registrar) (b) Registrar

NOV 23 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/21/45 19..., at 1 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/1/45 19..., to 11/20 19 45 and that I last saw h** alive on 11/19 19 45

Immediate cause of death: Cerebral Coma — Duration: 2 wks.

Due to: Chronic Interstitial Nephritis — Duration: 5 yrs.

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: Wilbur T. Denton M. D.

Address: 2121 Edmondson Ave. Date signed 11/22/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(over)

X

G34377 BALTIMORE CITY HEALTH DEPARTMENT G34377

CERTIFICATE OF DEATH 83a

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 Days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 544 Bare St.
(If rural give location)
Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Wright

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed or divorced. Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/1/1895

8. AGE: Years 50 | Months 2 | Days 17 | If less than one day hr. min.

9. Birthplace Cumberland
(Town, county, and state)

10. Usual Occupation Labor

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Bare - M Patterson
(b) Address 1756 Wash Blvd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 24 45 (month) (day) (year)
(c) Cemetery or crematory Meadow Ridge Cem
Location Dorsey Md

18 (a) Funeral director Ambrose Inc
(b) Address 414 N. FRANKLINTOWN

19 (a) NOV 23 1945 Huntington Williams (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 18th 1945 at 10 55 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Intra-cranial hemorrhage.

Due to

Other Conditions Broncho-pneumonia.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

Signature Benedict Stasulis M.D.
Medical Examiner.
Date signed 11-19-45

VS 151

G34378

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46E

Registered No. G34378

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Caldwell
(c) Hospital or institution:
Franklin Square 22
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5 mo

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 644 W Baltimore St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Rubasheosky Roberts

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. 214-05-3302

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife TEKLA.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years	Months	Days	If less than one day
71			hr. min.

9. Birthplace Lithuania
(Town, county, and state)

10. Usual Occupation Sailor

11. Industry or business

FATHER
12. Name Joseph Roberts
13. Birthplace Lithuania

MOTHER
14. Maiden Name ?
15. Birthplace Lithuania

16 (a) Informant Sophia Bartell
(b) Address 626 W. Fayette, apt

17 (a) Burial (b) Date thereof NOV 24-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem
Location Baltimore Md

18 (a) Funeral director Joseph Kasimakas Dir
(b) Address 602 Washington Blvd

19 (a) NOV 27 1945 (b) Registrar
(Date rec'd by registrar)

Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-21 1945, at 7:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-23 1945, to 11-21 1945, and that I last saw him alive on 11-21 1945.

Immediate cause of death	Duration
Cardiospasm	
Due to Carcinomatosis	
Due to Carcinoma of Sigmoid	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(c) Means of injury

23. Signature H. K. Kazanjian M. D.
Address Franklin Square Hosp. Date signed 11-24-45

H. K. Kazanjian

Dr. Insley — Balto. & Pabst Bldg. 343-3

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1312

G34379 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 12½ N. Decker Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 - 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 12½ N. Decker Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Milton Harry Stockett

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-07-2209

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	MARRIED

6 (b) Name of husband or wife Mabel -
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 1 - 1888

8. AGE: Years	Months	Days	If less than one day
57	3	19	hr. min.

9. Birthplace Baltimore - Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Charles Stockett
13. Birthplace Md

MOTHER
14. Maiden Name Mary Hagen
15. Birthplace Md.

16 (a) Informant Mrs. Mabel Stockett
(b) Address 12½ N. Decker Ave.

17 (a) Burial (Burial, cremation, or remove) (b) Date thereof 11-22-45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Rd.

19 (a) (b) Huntington Nelligan Registrar

NOV 23 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 20 - 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 14 1945 to Nov 20 45, and that I last saw h— alive on Nov 19 45

Immediate cause of death — Duration

Cerebral Hemorrhage

Due to Chronic Nephritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Knox Insley M. D.
Address 7536 Eastern Ave Date signed Nov 23 45

PHYSICIAN

Underline the cause to which death should be charged statistically.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634380

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 634380

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Cotton Aves
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 2d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: Baltimore
(a) State Md (b) County Carroll
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 1307 Sulphur Spring Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Wesley Wilson
3 (b) If veteran, name war No
3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widower
6 (b) Name of husband or wife Ivy A.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept 18 1875
8. AGE: Years 70 | Months 2 | Days 3 | If less than one day hr. min.
9. Birthplace Md (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name John Wilson
13. Birthplace Md

MOTHER
14. Maiden Name Harriet
15. Birthplace Md

16 (a) Informant Mrs. Ivy A. Wilson
(b) Address 1312 Poplar Ave. Balto 27. Md

17 (a) Funeral (b) Date thereof 11/24/45 (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory Greenmount
Location Baltimore Md

18 (a) Funeral director Wilson Funeral Home
(b) Address 1719 Pennsylvania Ave

19 (a) (b) Registrar
(Date rec'd by registrar)

VS 150 NOV 23 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-21- 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-15 19 , to 19 , and that I last saw h alive on 19 .

Immediate cause of death Acute Coronary Occlusion — Duration
Due to Arteriosclerotic Hypertensive C-V Disease (Chronic)
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chas. E. Gardner
Address St Agnes Hosp Date signed 11/22/45 M.D.

G34381

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G34381 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 506 W. Lexington St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edward Yager

3 (b) If veteran, name war	3 (c) Social Security Account No.
~	~

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	~

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years	Months	Days	If less than one day
64			hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Tony Unknown
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Sarah Berger
(b) Address 506 W. West St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-23-45 (month) (day) (year)
NOV 23
(c) Cemetery or crematory Mt Auburn
Location Balto City

18 (a) Funeral director Isaiah L. Brown & Son
(b) Address 108 W Montgomery St

19 (a) (Date rec'd by registrar) (b) Registrar

NOV 23 1945

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-19-1945 at 11 5 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage, Spontaneous

Due to

Other Conditions Generalized arteriosclerosis, Hypertrophy of Heart - dilatation; Chronic Myocarditis, Etc.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard D. Mallett M.D.
Medical Examiner.
Date signed 11-20-45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34382 — BALTIMORE CITY HEALTH DEPARTMENT — G34385

CERTIFICATE OF DEATH 1/21a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1011 S. Sharp st
(c) Hospital or institution: 23
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 36 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore — (If outside city or town limits, write RURAL and give town)
(d) Street No. 1011 S. Sharp st (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eva Harris

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife James Harris
6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) Mar 4 1895

8. AGE: Years 50 | Months 8 | Days 14 | If less than one day hr. min.

9. Birthplace Richmond - Va
(Town, county, and state)

10. Usual Occupation Home
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Mahaley Palmer
15. Birthplace Richmond Va

16 (a) Informant Edith Key
(b) Address 1011 S Sharp St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 23 45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A.A. Co. Md

18 (a) Funeral director Isaac L Brown Son
(b) Address 108a Montgomery Street

19 (a) (Date rec'd by registrar) (b) Registrar Huntington Williams, M.D.
NOV 23 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov-18 1945, at 4 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/11 1943 to 11/18 1945, and that I last saw h[illegible] alive on 11/18 1945.

Immediate cause of death	Duration
Pneumonia	2 Days
Due to Hypostatic pneumonia	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature David Brumbaugh M. D.
Address [illegible] Date signed 11/19/45

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34383

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

G34383

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N Broadways
(c) Hospital or institution:
Church Home & Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 37days
(e) Length of stay in Baltimore (yrs., mos., or days) 37 days

2. USUAL RESIDENCE OF DECEASED:
(a) State NY (b) County
(c) City or town New York City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4 Sutton Place
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ALEXANDER, MRS. HELEN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. married.

6 (b) Name of husband or wife Mr. Henry Alexander.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June ? 1870

8. AGE: Years 75 | Months 5 | Days ? | If less than one day hr. min.

9. Birthplace New York City, N.Y.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name William De Forest Morrison

13. Birthplace New York

MOTHER 14. Maiden Name Josephine Leonard

15. Birthplace Mass. (?)

16 (a) Informant E. Forrest Alexander

(b) Address NEW York

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/23/45 (month) (day) (year)

(c) Cemetery or crematory Greenwood Cem

Location New York City N.Y.

18 (a) Funeral director Wilson & Son

(b) Address 1217 E Fort St

19 (a) (Date received by registrar) (b) Registrar M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-22 1945, at 3.45P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-17 1945, to 11-22 1945, and that I last saw h[illegible] alive on 11-22 1945.

Immediate cause of death Pulmonary atelectasis — Duration 36 hrs.

Due to Intestinal obstruction from paralytic ileus & fecal impaction — Duration

Due to Fracture of neck of femur - Right — Duration 37 days.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 10-19-45, 11-13-45

Major findings of operation: Fracture of

of autopsy: RA above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 10-10-45 at M
(c) Where did injury occur? Hot Springs (City or town) Va (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Public place (Specify type of place) While at work? No
(e) Means of injury Slipped on a Step

23. Signature Frank M. Slingluff M. D.

Address Church Home & Hosp. Date signed 11-23-45

Huntington Atkinson M.D.

Benedict Skutarelic M.D.

G34384 BALTIMORE CITY HEALTH DEPARTMENT G34384

CERTIFICATE OF DEATH 94a

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 523 Denison
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FREDERICK W. DRESSEL, JR.

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	213-10-0322

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of ~~husband or~~ wife Katherine A. Dressel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 22, 1885

8. AGE: Years	Months	Days	If less than one day
60 ~~yrs~~	9	0	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Shop Foreman
11. Industry or business Baltimore Transit Co.

FATHER
12. Name Frederick W. Dressel, Sr
13. Birthplace Germany

MOTHER
14. Maiden Name Jennie Beckman
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Katherine A. Dressel
(b) Address 523 Denison St.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 26th 1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Wm. J. Tickner & Sons.
(b) Address North & Penna Aves.

19 NOV 23 1945 (Date rec'd by local registrar) Huntington Williams, Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/22/45 19 , at 8:20 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes [X], accident [ ], suicide [ ], homicide [ ], undetermined [ ] and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary [ ] or contributing [ ] cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Weis, M.D.
Medical Examiner.
Date signed 11/22/45

G34385

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

171a

G34385 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1521 Linden Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alberta Barrett

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband: Andrew J. Barrett

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 27-1875

8. AGE: Years 70 | Months 4 | Days 24 | If less than one day hr. min.

9. Birthplace Kingsville, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business Home

FATHER
12. Name James F. Cloman
13. Birthplace Cecil County, Md.

MOTHER
14. Maiden Name Agnes A. Moore
15. Birthplace Kingsville, Md.

16 (a) Informant Mrs. Agnes Sneeinger (daughter)
(b) Address 623 St Dunston Roa d.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof November 24-1945 (month) (day) (year)
(c) Cemetery or crematory St. John's Espiscopal
Location Kingsville, Md.

18 (a) Funeral director Wm. J. Tickner & Sons.
(b) Address North & Penna Aves.

19 (a) NOV 23 1945 (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 21, 1945, at 9 P. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Depressed fracture of skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-21-45 at 14/1 M.
(b) Where did injury occur Linden Ave 100' off Wilkens St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no
(d) Means of injury Pedestrian struck by streetcar

23. Signature Robert Lee Fortune M.D. Medical Examiner.
Date signed Nov. 22 1945

Hunterstown, Adams Co. Pa.

X

G34386

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1/22a

Registered No. G34386

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division ST
(c) Hospital or institution: Provident Hospital 9-9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1317 N. Central Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James Edward Dotson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	N	M

6 (b) Name of husband or wife Elizabeth Dotson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-26-1876

8. AGE: Years	Months	Days	If less than one day hr.	min.
69	0	24		

9. Birthplace Carroll County Md (Town, county and state)
10. Usual Occupation Minister
11. Industry or business

FATHER
12. Name John W. Dotson
13. Birthplace Md

MOTHER
14. Maiden Name Elizabeth Thomas
15. Birthplace Md

16 (a) Informant James E. Dotson
(b) Address 1317 N. Central Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-24-45 (month) (day) (year)
(c) Cemetery or crematory Fair View Cem
Location Frederick, Maryland

18 (a) Funeral director Mrs Ida Bailey
(b) Address 1421 E. Jefferson Balto

19 (a) (Date received by Registrar) (b) Registrar

NOV 23 1945

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-20 1945, at 5 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-4 1945, to 11-20 1945, and that I last saw h/M. alive on 11-20 1945

Immediate cause of death Cerebral embolus — Duration

Due to Operation for bilateral inguinal hernia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 11-6-45

Major findings of operation: Bilateral inguinal hernia

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herbert Wilkerson Furbush M. D.
Address 1200 St Paul Date signed 11-21

X

45

G34387

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G34387

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3309 Virginia Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 16

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3309 Virginia Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CARL GRIMMER

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-03-4135

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of ~~husband or~~ wife Pauline

6 (c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) Aug. 16. 1873

8. AGE: Years	Months	Days	If less than one day
72	3	6	hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Continental Can Co

FATHER
12. Name Peter Grimmer
13. Birthplace Germany

MOTHER
14. Maiden Name Not Known
15. Birthplace Germany

16 (a) Informant Karl Grimmer
(b) Address 3303 Virginia Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-24-45 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Hillsdale Md.

18 (a) Funeral director George Leimbach
(b) Address 525 N. Aynsburst St

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/22/45 19 , at 7:10 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to ~~his~~ death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Vascular Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis, M.D.
Medical Examiner.
Date signed 11-27-45

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34388

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131 a

XV G34388 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 41
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balt.
(c) City or town Rural - Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1300 Old Frederick Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Dewey Smith

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-05-2688

4. Sex Male | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Helen Grant Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 23, 1901

8. AGE: Years 44 | Months - | Days 26 | If less than one day hr. min.

9. Birthplace West Moreland Co. Virginia
(Town, county, and state)

10. Usual Occupation Longshoreman

11. Industry or business

FATHER
12. Name Herman H. Weaver.
13. Birthplace Va..

MOTHER
14. Maiden Name Virginia Smith.
15. Birthplace Va..

16 (a) Informant Mrs. Helen G. Smith
(b) Address 1390 Old Frederick Rd. Baltimore Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 23 '45 (month) (day) (year)

(c) Cemetery or crematory Arbutus Memorial

Location

18 (a) Funeral director Mrs Katie R Williams

(b) Address 322 N Schroeder St Huntington Williams, Md

19 (a) NOV 23 1945 (Date rec'd by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-18-1945, at 3 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-7-1945, to 11-18-1945, and that I last saw him alive on 10-17 1945.

Immediate cause of death	Duration
Hypertensive Cardiovascular-renal disease	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm A Holbrook M. D.
Address Univ. Hosp. Date signed 11-18-45

VS 150

G34389 ✓ G34389

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93c

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1/2d.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County B
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1833 N. Patterson Park Ave
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Martin J. Kerrigan Jr

3 (b) If veteran, name war —

3 (c) Social Security Account No. 705-05-37N

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Irene J. Kerrigan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/16/1893

8. AGE: Years	Months	Days	If less than one day
52	10	6	hr. min.

9. Birthplace Balto
(Town, county, and state)
10. Usual Occupation Rate-Clerk
11. Industry or business

FATHER
12. Name Martin J. Kerrigan Sr.
13. Birthplace Balto. Ireland

MOTHER
14. Maiden Name Catherine Mooney
15. Birthplace Ireland.

16 (a) Informant Mrs. J. Kerrigan
(b) Address 1833 N. Patterson Park Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-24-45 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore Md.

18 (a) Funeral director Flynn & Flynn
(b) Address 1476 Light St.

19 (a) NOV 29 1945 (b) Huntington Williams, M.D.
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/21 1945, at 12:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/20 1945, to 11/21 1945, and that I last saw him alive on 11/20 1945.

Immediate cause of death	Duration
Rheumatic Cardio-Vascular disease with decompensation	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles Stuart Jr M.D.
Address Mercy Hosp. Date signed 11/24/45

X

G34390

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1312

G34390 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1531 Linden Ave.
(c) Hospital or institution: 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 19 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1531 Linden Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian Hanway Boyd

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: William E Boyd
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/29/88

8. AGE: Years 57 | Months 6 | Days 21 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER
12. Name T. L. Hanway
13. Birthplace Md.

MOTHER
14. Maiden Name Eliz. Morgan
15. Birthplace Md.

16 (a) Informant William E. Boyd
(b) Address 1531 Linden Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/23/45 (month) (day) (year)
(c) Cemetery or crematory Grove Cemetery
Location Aberdeen Maryland

18 (a) Funeral director John. C Mitchell & Son.
(b) Address 1900 Eutaw Pl.

19 (a) (Date rec'd by registrar) (b) Registrar

NOV 23 1945

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/20 1945 at 9- M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-2 1945, to 11/20 1945, and that I last saw h[illegible] alive on 11/14 1945

Immediate cause of death	Duration
uremic intoxication	7 days
Due to cardio-renal disturbance	2 yrs
Due to Interstitial nephritis	
Other Conditions arthritis & heart-arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature S. Duncan Jr M. D.
Address Med. Arts Bldg. Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34391

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131 a

G34391 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 521 E. 21. Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 521. E. 21st St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Barbara Brandmiller

3 (b) If veteran, name war –
3 (c) Social Security Account No. –

4 Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife –
6 (c) If alive, give age – years

7. Birth date of deceased (mo., day, yr.) 1868

8. AGE: Years 77 | Months – | Days – | If less than one day ... hr. ... min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation
11. Industry or business Home Keeper.

FATHER
12. Name Michael Brandmiller
13. Birthplace Germany

MOTHER
14. Maiden Name Katherine Martini
15. Birthplace Germany

16 (a) Informant Joseph Brandmiller
(b) Address 521 E. 21st St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-24-1945 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cemetery
Location

18 (a) Funeral director Mary W. Wedefeld
(b) Address 501 E. 22nd St

19 (a) (Date received by registrar) (b) Registrar

VS NOV 23 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH November 21. 1945, at 5a M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 14 1945 to Nov 21 1945, and that I last saw her alive on Nov 20 1945.

Immediate cause of death: Cerebral arteriosclerosis with Encephalomalacia — Duration 7 years
Due to
Due to Chr. Interstitial Nephritis — years
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature William L. Straughn M.D.
Address 10 E. Biddle St Date signed 11/23/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634392

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83 ✓

Registered No. 634392

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1732 Warwick Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and name town)
(d) Street No. 1732 Warwick Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Weinberg
3 (b) If veteran, name war
(c) Social Security Account No.
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Bessie
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1892
8. AGE: Years 53 | Months | Days | If less than one day hr. min.
9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Cutter
11. Industry or business

FATHER
12. Name Lemoz
13. Birthplace Russia

MOTHER
14. Maiden Name Anna
15. Birthplace Russia

16 (a) Informant Bessie Weinberg
(b) Address 1732 Warwick Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-23-45 (month) (day) (year)
(c) Cemetery or crematory Rawlet
Location Pikesville Baltimore Co

18 (a) Funeral director Jas C Sems Son
(b) Address 1432 E Baltimore St

19 (a) (Date received by Registrar) NOV 23 1945 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-21-1945 at 10P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 14 1941 to Nov. 21 1945, and that I last saw him alive on Nov. 1945.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Arteriosclerosis	
Due to	
Other Conditions Hemiplegia cerebellar ataxy (Include pregnancy within 3 months of death)	June/45

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature N. E. Needle M. D.
Address 7314 W. North Ave Date signed 11/23/45

X

G34393

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a ✓

G34393 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1210 E. Biddle Street
(c) Hospital or institution; 10

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1210 E. Biddle Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME: William Henry Wiedefeld Sr.

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 216-03-6666

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary C. Jones

6 (c) If alive, give age 39 years

7. Birth date of deceased (mo., day, yr.) Sept. 12, 1896

8. AGE: Years 49 | Months 2 | Days 10 | If less than one day ##### hr. ##### min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Chauffeur

11. Industry or business: Shepherd Electric Co.

FATHER: 12. Name James F. Wiedefeld
13. Birthplace Baltimore, Md.

MOTHER: 14. Maiden Name Georgena Mattern
15. Birthplace Pennsylvania

16 (a) Informant: Mrs. Mary C. Wiedefeld
(b) Address 1210 E. Biddle Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/26/45 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cemetery
Location Eastern Avenue, Balto; Co

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) (Signature of local registrar) (b) Williamsport, Md.
NOV 23 1945 Huntington
VS 126

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 22nd 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/18 1945, to 11/22 1945, and that I last saw h[illegible] alive on 11/Sat 1945

Immediate cause of death: Coronary Thrombosis — Duration: Sudden

Due to: Cardio Vascular Renal Disease — Duration: ?

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph A. Blum, M.D.
Address 1206 E. Preston St Date signed 11/22/45

G34394

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

52B

Registered No. G34394

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1531 Hanover St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 918 S. Charles St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Mary Amos

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife William Amos
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 14, 1869

8. AGE: Years	Months	Days	If less than one day
76	9	6	hr. min.

9. Birthplace Frederick Co., Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name Jacob Turner
13. Birthplace Maryland

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mr Harry S. Clem
(b) Address 3613 Keystone Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/23/45 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Annapolis Blvd.

18 (a) Funeral director John F Hennessy Inc
(b) Address 7 E. Eight St.

19 (a) (Date rec'd by registrar) (b) Registrar

NOV 23 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 20th 1945, at 5 45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/5 1943 to 11/20/1945 and that I last saw h. alive on 11/19 1945

Immediate cause of death Carcinoma of the bladder with general metastases — Duration 2

Due to — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dr Harry Diehl M. D.
Address 1226 Hanover St. Date signed 11/29/45

X

G34395

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G34395 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2906 Sylvan Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2906 Sylvan Ave. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Mrs Virginia Carter Regester

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Robert Asbury Regester
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-24-1851

8. AGE: Years 94 | Months 7 | Days 27 | If less than one day hr. min.

9. Birthplace York, Md. (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER — 12. Name Joshua Carter
13. Birthplace Maryland

MOTHER — 14. Maiden Name Ellen Treadwell
15. Birthplace Maryland

16 (a) Informant Mrs Catherine Wentz
(b) Address 2906 Sylvan Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/24/45 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Woodlawn Md

18 (a) Funeral director H. W. Means & Son
(b) Address 805 N. Calvert St.

19 (a) (b)

NOV 23 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 22 1945, at 11:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1 1945, to Nov. 22 1945, and that I last saw her alive on Nov. 22 1945

Immediate cause of death Cerebral Hemorrhage — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. F. Cole M. D.
Address 6014 York Road Date signed 11-22-45

Huntington Hilliard

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34396

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G34396 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33 Calvert
(c) Hospital or institution: Union Memorial Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 74 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 201 West Madison St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. ~~Clarence Jones~~ Grieves, (Hannah Ramsay)

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Clarence Jones Grieves
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 1, 1871

8. AGE: Years 74 | Months 1 | Days 22 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Mr James D. Ramsay
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Hannah Littig
15. Birthplace Baltimore, Md.

16 (a) Informant Miss Helen M. Bordley
(b) Address Evesham, Bowans, Balto., Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-24-45 (month) (day) (year)
(c) Cemetery or crematory Green Mount.
Location Baltimore.

18 (a) Funeral director Sturdivant Moore & Co.
(b) Address 108 W Franklin St

19 (a) (Date received by registrar) (b) Huntington Williams, M.D.

NOV 23 1945
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 22 1945 at 7.05 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 20 1945, to Nov. 22 1945, and that I last saw h.e.r. alive on Nov. 22 1945.

	Duration
Immediate cause of death Acute cardiac failure	
Due to Arteriosclerotic heart disease	
Due to	
Other Conditions Metastatic carcinoma of lung from left breast	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Huntington Williams M.D.
Address Union Memorial Hospital Date signed 11-22-45

X

G34397

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G34397

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4626 Bowleys Lane
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 4626 Bowleys Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HENRY G. GRAF

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-05-3109

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Theresa M. Ulrich
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 2, 1879

8. AGE: Years	Months	Days	If less than one day
66	7	20	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Elevator Operator
11. Industry or business

FATHER
12. Name Henry Graf
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Frederick
15. Birthplace Germany

16 (a) Informant Mrs. H. G. Graf
(b) Address 4626 Bowleys Lane

17 (a) burial (Burial, cremation, or removal) (b) Date thereof Nov. 26, 1945 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto., Md.

18 (a) Funeral director Kaufmann Funeral Home
(b) Address 7401 Belair Road

19 (a) (Date rec'd by registrar) (b) Registrar

NOV 25 1945

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 22, 1945, at 9 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1, 1945 to Nov. 22, 1945 and that I last saw him alive on Nov 21, 1945.

Immediate cause of death	Duration
Coronary Thrombosis	4 hours
Due to Arteriosclerosis	?
Due to	
Other Conditions Hyperacidity (Gastric)	2 days

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Eugene L. Casazza M. D.
Address 514 Downs Lane Date signed 11/23/45

X Casazza

G34398

Found: North Point Road & Penna. R. R.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G34398 Registered No. 171c (over)

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Baltimore City Hospital 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) d.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 708 Sterling Street
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME ANDREW JEFFERSON

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No.:
4. Sex: Male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Unknown
6 (b) Name of husband or wife.....
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1890
8. AGE: Years 55 | Months | Days | If less than one day .....hr. .....min.
9. Birthplace Va (Town, county, and state)
10. Usual Occupation.....
11. Industry or business.....
FATHER 12. Name ?
13. Birthplace.....
MOTHER 14. Maiden Name ?
15. Birthplace.....
16 (a) Informant John Woodson
(b) Address 708 Sterling St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/24/45 (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location.....
18 (a) Funeral director Joseph B. Lotz, Jr.
(b) Address 1804 N. Central Ave
19 (a) Huntington Williams, M.D. Registrar
(Date received by registrar)
W 23 1945
VS-151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 14, 1945, at 9:25 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Probable
Skull fracture
Intracranial hemorrhage
Due to.....
Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Unknown M.
(b) Where did injury occur? Unknown
(c) Did injury occur at home, on farm, industrial place, in public place? Unknown While at work? Unknown
(d) Means of injury Unknown
23. Signature Benedict Steinecke M.D.
Medical Examiner.
Date signed 11-15-45

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34399 BALTIMORE CITY HEALTH DEPARTMENT G34399
CERTIFICATE OF DEATH 169

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baton & Wilkens Ave.
(c) Hospital or institution:
St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1/2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Howard
(c) City or town Ellicott City
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Locke Albright

3 (b) If veteran, name war None
3 (c) Social Security Account No. None

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 16, 1934

8. AGE: Years 11 | Months 10 | Days 6 | If less than one day ..... hr. ..... min.

9. Birthplace Hawkins Co. Tenn.
(Town, county, and state)

10. Usual Occupation Student

11. Industry or business

FATHER
12. Name Nelson Albright
13. Birthplace Tennessee

MOTHER
14. Maiden Name Birdie Miller
15. Birthplace Tennessee

16 (a) Informant Nelson Albright
(b) Address Ellicott City, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 24/45 (month) (day) (year)
(c) Cemetery or crematory Taylor Family Cem.
Location Ellicott City, Md.

18 (a) Funeral director Easton Sons
(b) Address Ellicott City, Md.

19 (a) (Date received by Registrar) (b) Huntington Williams, M.D.

NOV 23 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH November 22, 1945, at 1 40 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-19-45 at 4:30 P. M.
(b) Where did injury occur? Ellicott City, Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian struck by train

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Nov 22 1945

X

G34400

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G34400 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address U.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1241 Wash. Blvd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Thompson

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, ~~married, widowed, or divorced~~
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/22/45

8. AGE: Years	Months	Days	If less than one day
			1 hr. 55 min.

9. Birthplace Balto, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James Thompson
13. Birthplace Balto, Md.

MOTHER
14. Maiden Name Jane T Neumand
15. Birthplace Md

16 (a) Informant Mr James Thompson
(b) Address 12 04 Washington Blvd

17 (a) Burial (b) Date thereof 11/24/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location East North Ave

18 (a) Funeral director H. H Withee
(b) Address 4101 Edmondson Ave

19 (a) (b)
(Date received by Registrar) Registrar
~~NOV 23 1945~~ Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/22 1945, at 6.45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/22 1945, to 11/22 1945, and that I last saw h[illegible] alive on 11/22 1945.

Immediate cause of death	Duration
Prematur	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] Gh. Agnes

Address Date signed 11/22/45

X

G34401 — BALTIMORE CITY HEALTH DEPARTMENT ✓ — G34401

CERTIFICATE OF DEATH 106c

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2133 W. Saratoga St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2133 W. Saratoga St.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME DELORES V. HRABAL

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age X years
7. Birth date of deceased (mo., day, yr.) July 17, 1942
8. AGE: Years 3 | Months 4 | Days 5 | If less than one day: hr. min.
9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Gordon S. Hrabal
13. Birthplace Texas

MOTHER
14. Maiden Name Mildred E. Connelly
15. Birthplace Maryland

16 (a) Informant Mildred E. Hrabal
(b) Address 2133 W. Saratoga St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-24-45 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore, Md.

18 (a) Funeral director George L. Schnabel
(b) Address 2101 Frederick Ave. Huntington Williams, M.D.

19 (a) NOV 23 1945 (Date received by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 22 1945, at 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 20 1945 to Nov. 22 1945 and that I last saw her alive on Nov. 21 1945.

Immediate cause of death: Obstruction of Larynx — Duration: 2 days
Due to: Acute Tracheo-Laryngo-Bronchitis — 2 days
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Homer C. Dodd M.D.
Address 2108 St. Paul St. Date signed 11/23/45

X

G34402

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163H

G34402 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, give RURAL and township)
(d) Street No. 1837 W. Lexington
(If rural give direction)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Henry C. Stolzenbach (Stolzenbach)

3 (b) If veteran, name war: World War II
3 (c) Social Security Account No. 215-05-4284
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Divorced
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) April 19, 1918
8. AGE: Years 27 | Months 7 | Days 2 | If less than one day hr. min.
9. Birthplace Baltimore, Md. (Town, county and state)
10. Usual Occupation Crane Rigger
11. Industry or business Baltimore Rigging Co.

FATHER
12. Name John Stolzenbach
13. Birthplace Maryland

MOTHER
14. Maiden Name Lula Markmyer
15. Birthplace Maryland

16 (a) Informant John Stolzenbach
(b) Address 603 Bristol Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-24-45 (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location Baltimore, Md.
18 (a) Funeral director George L. Lehnert
(b) Address 2101 Frederick Ave.
19 (a) 11-23-1945 (Entered by registrar) (b) Huntington for Hillmann M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 21 1945, at 2 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy-Inq. thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carbon monoxide poisoning.

Due to Illuminating gas.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11/21/45 at 2 P. M.
(b) Where did injury occur? 1837 W. Lexington
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no
(d) Means of injury Gas burner on Entrance.

23. Signature Benedict Whitarelli M.D. Medical Examiner.
Date signed 11-21-45

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34403

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. GB 94433

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mount Hope Retreat 20
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24-10-4
(e) Length of stay in Baltimore (yrs., mos., or days) 56-10-23

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1842 W. Fayette St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Margaret M. Echle

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 29, 1889

8. AGE: Years 55 | Months 10 | Days 23 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Book Keeper

11. Industry or business

FATHER 12. Name Adam F. Echle
13. Birthplace Cumberland, Md.

MOTHER 14. Maiden Name Margaret Fahey
15. Birthplace Ireland

16 (a) Informant Mount Hope Retreat
(b) Address 6420 Reisterstown Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-24-45 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem. Location Balto Md

18 (a) Funeral director Geo A Smith
(b) Address Fulton Ave & Lafayette

19 (a) (Date rec'd by registrar) NOV. 24 1945 (b) Huntington Hill Registrar, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 22 1946, at 8:22 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 1934, to Nov. 22 1945, and that I last saw h[illegible] alive on Nov. 22 1945.

	Duration
Immediate cause of death: Repeated Manic maniacal Injuries	8 mos.
Due to	
Due to	
Other Conditions: Schizophrenia	24 yrs.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. P. Alagia M. D.
Address 33 W Baltimore St Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34404

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G34404 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 110 S London Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 110 S London Ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Florence M Hobbs

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife George J.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 22 1875

8. AGE: Years 70 | Months 8 | Days - | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Armon T Hamilton

13. Birthplace Md

MOTHER 14. Maiden Name Mary E McDermott

15. Birthplace N Y

16 (a) Informant Jane Cayle Griffin

(b) Address 110 S London Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-26-45 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Baltimore Md

18 (a) Funeral director George G Staley

(b) Address Fulton & Fayette

19 (a) (Date rec'd by registrar) (b) Registrar

NOV 24 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 22 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 10 1945 to Nov. 20 1945 and that I last saw h er alive on Nov. 20 1945.

	Duration
Immediate cause of death Nephritis	2 mos
Due to Arterio-sclerosis	7 yrs?
Due to Cardio-Vascular-Renal Disease	7 yrs?
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify which) Whil at work?
(e) Means of injury

23. Signature George Elbert

Address 603 Stirling Rd Date signed 11-27-45

Huntington Williams, M.D. Catonsville Md

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34405

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

123

Registered No. G34405

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital, Balto., Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) 13 days

2. USUAL RESIDENCE OF DECEASED:
(a) State New Jersey (b) County
(c) City or town Ridgewood
(If outside city or town limits, write RURAL and give town)
(d) Street No. 207 Pershing Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME
Johanna Daisy Redyke

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 5, 1921

8. AGE: Years	Months	Days	If less than one day
24	0	18	hr. min.

9. Birthplace Midland Park, New Jersey
(Town, county, and state)
10. Usual Occupation Ph. Mate 3/c
11. Industry or business US Navy Wave

FATHER
12. Name John Redyke
13. Birthplace Midland Park, New Jersey

MOTHER
14. Maiden Name Rica Boresma
15. Birthplace Holland

16 (a) Informant Records
(b) Address U. S. Marine Hospital, Balto. Md.

17 (a) Burial (b) Date thereof Nov. 26 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Midland Park - N.J.

18 (a) Funeral director Adler Funeral Home, Inc.
(b) Address 4644 York Road.

19 (a) (b)
(Date rec'd by Local Reg.) Registrar

NOV 24 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 23 1945 at 3:35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 11 1945, to Nov. 23 1945, and that I last saw her alive on Nov. 23 1945.

Immediate cause of death Peritonitis
with intestinal perforation — Duration 12 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Senior Surgeon M. D.
Address Clinical Director Date signed 11/23/45

U. S. Marine Hospital, Balto., Md.

G34406

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

G34406 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 328 Whitridge Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 328 Whitridge Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katie Medford.

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	W.

6 (b) Name of husband or wife Charles.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 18 1877

8. AGE: Years	Months	Days	If less than one day
68	2	3	hr. min.

9. Birthplace Balto. (Town, county, and state)
10. Usual Occupation ✓
11. Industry or business

FATHER
12. Name Owen Crosson.
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Lydia Hahnemann
(b) Address 328 Whitridge Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/26/45 (month) (day) (year)
(c) Cemetery or crematory St Louis Cem.
Location Annapolis Md

18 (a) Funeral director Wm Cook Inc
(b) Address 1217 St Paul St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams Registrar, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 21 1945 at 7 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1945, to Nov. 21 1945, and that I last saw h[illegible] alive on Nov. 21 1945.

Immediate cause of death	Duration
Carcinoma of rectum and metastasis	4 mo.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation August 30, 1945
Major findings of operation: same
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature]
Address 6217 Harford Rd Date signed M. D. 4/24/46

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34407

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G34407 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 34 Lloyd St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 34 Lloyd St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Mary A. Behnke

3 (b) If veteran, name war: no | 3 (c) Social Security Account No. none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: August

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 4 1859

8. AGE: Years 86 | Months 3 | Days 18 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name (Unknown) Stockfish
13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Ella (Unknown)
15. Birthplace Baltimore Md

16 (a) Informant Ora Thomas
(b) Address 34 Lloyd St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/24/45 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location Baltimore Md

18 (a) Funeral director Wilhelm Corp Inc
(b) Address 1217 E Fort Ave

19 (a) NOV 24 1945 (Date rec'd by registrar) (b) Huntington Williamsett M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 22 1945 at 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1945 to Nov 1945 and that I last saw her alive on Early in Nov 1945.

Immediate cause of death: Coronary thrombosis
Due to: Arteriosclerosis
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry A. Thomas M. D.
Address 11 E Biddle St Date signed 11/23/45

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34:08

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946 B

G34:08 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2037 N Lanvale St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2037 N Lanvale St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Edward Kroll

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Emma M Kroll
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 4, 1866

8. AGE: Years 79 | Months 7 | Days 18 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Furniture finisher

11. Industry or business

FATHER 12. Name Unknown
13. Birthplace Germany

MOTHER 14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mary Emma Kroll
(b) Address 2037 N Lanvale St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/26/45
(month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director Wilhorn Lodge Inc
(b) Address 1210 E Lanvale St

19 (a) NOV 21 1945 (b) Interment Williams, M.B.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 22 1945, at 7:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1945, to Nov 22 1945, and that I last saw him alive on 11/20/45 19

Duration

Immediate cause of death: Bronchial Acute Pneumonia — 2 days
Due to: Cancer Stomach — 2 yrs
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John J Gordon M. D.
Address 40 E Lanvale St Date signed 11/23/45

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34409 — 6

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G34409 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2312 Madison Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-13
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2312 E. Madison Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CATHERINE R. LACHER

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife George M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 7, 1879

8. AGE: Years	Months	Days	If less than one day
66	1	16	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Edward L. Harman
13. Birthplace Anne Arundel County, Maryland

MOTHER
14. Maiden Name Rosa Wagner
15. Birthplace Baltimore, Maryland

16 (a) Informant George M. Lacher
(b) Address 2312 E. Madison Street

17 (a) Burial (b) Date thereof Nov. 26, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Maryland

18 (a) Funeral director William Cook, Incorporated
(b) Address 1217 St. Paul Street

19 (a) NOV 24 1945 (b)
(Date rec'd by registrar) Huntington Williams M.D. registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/23 1945 at 12:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-1 1945 to 11/23 1945 and that I last saw her alive on 11/24 1945

Immediate cause of death Cerebral Hemorrhage — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dr. Ethel F. Lawthorne M. D.
Address 1076 S. East Ave Date signed

VS 150

X 11/23/45

634:10

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

634:10 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2905 Louisa Ave.
(c) Hospital or institution: Union Memorial Hospital, Baltimore, Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Mo. 90 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2905 Louisa Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Gladstone B. Adams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Mrs. Dorothea Adams
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 12, 1899

8. AGE: Years	Months	Days	If less than one day
46	5	12	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Office
11. Industry or business

FATHER 12. Name John Quincy Adams
13. Birthplace Maryland

MOTHER 14. Maiden Name Fannie Bailey
15. Birthplace Maryland

16 (a) Informant Dorothea Adams
(b) Address 2905 Louisa Ave

17 (a) Burial (b) Date thereof 11/27/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Parkville Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) 1945 (b) Nov 24 1945 Huntington Whitehead M.D.
(Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 23, 1945, at 3:35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/22/1945 to 11/23/1945, and that I last saw h/ alive on 11/22/1945

Immediate cause of death	Duration
Hypertensive Cardiovascular Disease	
Due to Cerebral thrombosis, left.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 11/13/45
Major findings of operation:
of autopsy: Mesenteric thrombosis? Arteriosclerosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo. W. Humphreys Jr. M. D.
Address 332 E. Univ. Pkwy. Date signed 11/27/45

(OVER)

939

G34411 — BALTIMORE CITY HEALTH DEPARTMENT — G34411

CERTIFICATE OF DEATH 46 E

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2211 E. Fayette St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 -
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Harford Co. Md. 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna J. Thompson

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Robert J. Thompson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 31-1895

8. AGE: Years	Months	Days	If less than one day
50 53	5	22	hr. min.

9. Birthplace Harford Co. Md.
(Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name John Trautner
13. Birthplace Germany

MOTHER
14. Maiden Name Mansner
15. Birthplace Germany

16 (a) Informant Mr. Robert J. Thompson
(b) Address 2211 E. Fayette St

17 (a) Burial (b) Date thereof 11 24 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Philip Henry Sons
(b) Address 524 Orleans St

NOV 24 1945
(Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 22 1945 at 4A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 6th 1945 to Nov 22nd 1945, and that I last saw h[illegible] alive on 11/21/45 1945

Immediate cause of death acute dilatation of heart — Duration 3 days

Due to congestive failure of Hypertension — Duration 2

Due to

Other Conditions Generalized sclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. J. Jankin M. D.
Address 1062 N. Milton Ave Date signed 11/23/45

X

G34412

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157E

G34412
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Conn. (b) County
(c) City or town Bridgeport (If outside city or town limits, write RURAL and give town)
(d) Street No. 110 - Holly St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jacqueline Kraftchelick (Krafchik)
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-15-37

8. AGE: Years	Months	Days	If less than one day
8	7	8	hr. min.

9. Birthplace Conn. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Michalis Krafchik
13. Birthplace Conn.

MOTHER 14. Maiden Name Ethel Hilda.
15. Birthplace Conn.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/26/45 (month) (day) (year)
(c) Cemetery or crematory St. Michael's
Location Bridgeport, Conn.

18 (a) Funeral director John D. Mitchell & Sons
(b) Address 1600 Eutaw Place

19 NOV 24 1945 (b)
Registrar

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 23 1945, at 12 20 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 17 (17) 1945 to November 23 1945 and that I last saw her alive on Nov 23 1945.

Immediate cause of death	Duration
Cardiac Failure	1 hour
Due to Congenital Heart Disease (Pulmonic Stenosis)	8 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation November 23, 1945
Major findings of operation: Pulmonic stenosis + Enlarged Heart
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. C. Cannan III M. D.
Address Johns Hopkins Hospital Date signed 11/23/45

VS 150

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634413

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. 634413

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4509 Liberty Heights Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days) 1 yr, 3 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4509 Liberty Heights Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Clarence Seymour, Sr.

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mollie Reese Seymour
6 (c) If alive, give age 82 years

7. Birth date of deceased (mo., day, yr.) May 13, 1857

8. AGE: Years	Months	Days	If less than one day
88	6	8	hr. min.

9. Birthplace Mineral County, W. Va.
(Town, county, and state)
10. Usual Occupation Retired Farmer
11. Industry or business

FATHER
12. Name Felix Renick Seymour
13. Birthplace Petersburg, W. Va.

MOTHER
14. Maiden Name Elizabeth Ann Welton
15. Birthplace Petersburg, W. Va.

16 (a) Informant Mr. Charles C. Seymour, Jr.
(b) Address 4605 Maine Ave

17 (a) Burial (b) Date thereof Nov. 24, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemetery
Location Woodlawn, Md.
18 (a) Funeral director Miller Funeral Home
(b) Address 4510 Liberty Heights Ave.
19 (a) Date received NOV 24 1945 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 21 1945, at 9.05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 16 1945 to Nov 21 1945 and that I last saw h. 1m alive on Nov 21 1945.

Immediate cause of death Cerebral Vascular Accident — Duration 5 days
Due to Arteriosclerosis Cardio Vasc — 10 yrs
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature John T Abbott M. D.
Address 4509 Liberty Hgts Ave Date signed

Huntington Williams, M.D.

M. D. B. 1266-b

G34414 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 183a G34414

CERTIFICATE OF DEATH

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 901 h. Strucker St., 16-2 Ward)

Registered No.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 50 yrs. ..... mos. ..... ds. How long in U. S. If of foreign birth? ..... yrs. ..... mos. ..... ds.

2. FULL NAME Jacida Brown

(a) Residence: No. 901 h. Strucker St., 16th Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	Colored	married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Edward Brown

6. DATE OF BIRTH (month, day, year) Sept 4, 1891

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
54	2 mo	17	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. domestic

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Same

10. Date deceased last worked at this occupation (month and year) the 7-17-45

11. Total time (years) spent in this occupation 43 yrs

12. BIRTHPLACE (city or town) (State or country) Calvert Serenty maryland

FATHER

13. NAME Elijah Adams

14. BIRTHPLACE (city or town) (State or country) Calvert County maryland

MOTHER

15. MAIDEN NAME margaret Thomas

16. BIRTHPLACE (city or town) (State or country) Calvert County maryland

17. INFORMANT Elizabeth Carroll
(Address) 2220 Penna Ave, Balto.

18. BURIAL, CREMATION, OR REMOVAL
Place Mt Calvary Date Nov 26 19 45

19. UNDERTAKER Wm Blocks
(Address) 1427 Carey St

20. NOV 24 1945 Huntington Williams M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) November 21, 1945

22. I HEREBY CERTIFY, That I attended deceased from 7-17- 19 45 to 11-21- 19 45

I last saw h. alive on 11-21- 19 45 Death is said to have occurred on the date stated above, at 8:10 p.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
arterio & clerosis	?
Cerebral hemorrhage	7-18-45
Acute nephritis	11-13-45

Other contributory causes of importance:

Name of operation None Date of

What test confirmed diagnosis? Physical Signs & symptoms Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? ..... Date of injury ....., 19.....

Where did injury occur? .....
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place .....

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? No If so, specify X

(Signed) John E. W. Lamper M. D.

(Address) 639 N. Carey St, Balto

Make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34415

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

G34415 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway
(c) Hospital or institution: Church Home Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3303 Walbrook ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Herbert Phillips

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex: M

5. Color or race: W

6 (a) ~~Single~~, married, ~~widowed~~, or ~~divorced~~: Married

6 (b) Name of husband or wife: Clara E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Oct. 1, 1861

8. AGE: Years 84 | Months 1 | Days 22 | If less than one day ..... hr. ..... min.

9. Birthplace: Mass. (Town, county, and state)

10. Usual Occupation: Dentist

11. Industry or business

FATHER
12. Name: George H. Phillips
13. Birthplace: Mass.

MOTHER
14. Maiden Name: Elvira Holbrook
15. Birthplace: Mass.

16 (a) Informant: Mrs. Clara E. Phillips
(b) Address: 3303 Walbrook Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/26/45 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: Frederick Rd.

18 (a) Funeral director: Wm. J. Tickner & Sons
(b) Address: North & Pa. Aves.

19 (a) ..... (Date rec'd by registrar) (b) ..... Registrar

NOV 24 1945

Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-23-1945 at 12 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-15-1945, to 11-23-1945 and that I last saw him alive on 11-23-1945.

Immediate cause of death	Duration
Arteriosclerotic	
Cardiovascular	
Disease - Failure	
Due to Jaundice	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Frank M. Shipley M. D.
Address: Church Home Staff. Date signed 11-23-45

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634416

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

634416 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 325 Paddington Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 325 Paddington Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: KATE P. SAYRE

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Gen. Farrand Sayre
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 10, 1864

8. AGE: Years 80 | Months 11 | Days 12 | If less than one day hr. min.

9. Birthplace St. Mary's, Ohio
(Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Dr. Charles M. Phelps
13. Birthplace St. Mary's, Ohio

MOTHER
14. Maiden Name Elizabeth Rhodes
15. Birthplace Ohio

16 (a) Informant Gen. Farrand Sayre
(b) Address 325 Paddington Rd.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11/24/45 (month) (day) (year)
(c) Cemetery or crematory
Location Junction City, Kansas

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b)
Registrar Hunting for Williamson, M.D.

VS 150 NOV 24 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 22, 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1940 to Nov 22 1945.
and that I last saw h[illegible] alive on Nov 21 1945 (Mo.)

Immediate cause of death: Cerebral Hemorrhage — Duration:
Due to: arteria-sclerosis with hypertension
Due to:
Other Conditions: none
(Include pregnancy within 3 months of death)

Date of operation: none
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide: no
(b) Date of occurrence at M
(c) Where did injury occur? none
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? none While at work?
(Specify type of place)
(e) Means of injury: none

23. Signature: A. Corbin Streett
Address 712 Park Ave. Balto. Md. Date signed Nov 23 1945

X

G34417

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1927

G34417 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2228 Sidney Ave
(c) Hospital or institution: 25

(d) Length of stay in hospital or inst. (yrs., mos., or days) Life
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2228 Sidney Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah J. C. Schlimm

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	married

6 (b) Name of husband or wife Otto L.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 9th 1860

8. AGE Years	Months	Days	If less than one day hr.	min.
65	4	14		

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housework
11. Industry or business at home

FATHER
12. Name Benj. Potter
13. Birthplace Cumberland, Md

MOTHER
14. Maiden Name Mary Connelly
15. Birthplace Cumberland

16 (a) Informant Mrs. Otto L. Schlimm
(b) Address 2228 Sidney Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/26/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location #4300 Old Frederick Road

18 (a) Funeral director John L. Bowman & Son
(b) Address 901-03 Hollins St.

19 (a) (Date rec'd by registrar) (b) Registrar

NOV 24 1945 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 23rd 1945, at 4:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from October 1939, to Nov 23 1945, and that I last saw her alive on Nov 23 1945.

Immediate cause of death	Duration
Chronic Valvular Heart Disease	
Due to	
Due to Cardiac Hypertrophy Cardiac Dilatation	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Vincent M. Mesmer M. D.
Address 1403 S. Charles St Date signed 11/23/45

X

G34418

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937 Registered No. G34418

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3208 Baker Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16-7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3208 Baker Street (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Harriett Cecelia Miller

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Harrison O. Miller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 15-1876

8. AGE: Years 69 | Months 5 | Days 7 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (City, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER 12. Name Robert Simonds
13. Birthplace Maryland

MOTHER 14. Maiden Name Mary Simonds
15. Birthplace Maryland

16 (a) Informant James O. Miller Sr.
(b) Address 3708 Baker Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 26-1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Marys Hampden
Location Baltimore, Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 363 Falls Road

NOV 24 1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D. (Registrar)

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 22 1945 at 6:45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 12 1940 to Nov 22 1945 and that I last saw h/w alive on Nov 21 1945

Immediate cause of death: Chronic cardiac decompensation

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
5 yrs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ernest A. Lakin

Address 1735 Poplar St Date signed 11/23/45

X

G34419

CWK-96026

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V55E

G34419 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Avenue

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 0- 2- 11

(e) Length of stay in Baltimore (yrs., mos., or days) 53 Yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 829 S. Dallas Street
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Zalinski

3 (b) If veteran, name war: World War 1

3 (c) Social Security Account No. 213-16-6219

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Catherine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 13-1893

8. AGE: Years 52 | Months 9 | Days 10 | If less than one day hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Thomas Zalinski
13. Birthplace Poland

MOTHER
14. Maiden Name Josephine Jacubich
15. Birthplace Poland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-26-45 (month) (day) (year)

(c) Cemetery or crematory Holy Rosary Cem
Location Baltimore County

18 (a) Funeral director John M. Webes
(b) Address 404 S. Chester Street

19 (a) NOV 24 1946 (b) Registrar
VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 23 1945, at 11 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 12 1945, to Nov. 23 1945, and that I last saw him alive on Nov. 23 1945.

Immediate cause of death Cachexia — Duration

Due to Carcinoma Ca + metastasis - to liver etc

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature E. A. Patronillet M. D.

Address BC-H Date signed 11-23-45

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34:20

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161

Registered No. G34:20

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2801 NORTH CHARLES STREET
(c) Hospital or institution: NONE 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) NONE
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County 12
(c) City or town CITY BALTIMORE.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2801 N. CHARLES STREET
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME RIGHT REVEREND MONSIGNOR ROBERT JOSEPH ACHSTETTER.

3 (b) If veteran, name war: -----
3 (c) Social Security Account No. ----

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: -----
6 (c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.) Aug. 29, 1878
8. AGE: Years 67 | Months 2 | Days 24 | If less than one day ____ hr. ____ min.
9. Birthplace Washington, D.C. (Town, county, and state)
10. Usual Occupation Catholic Priest
11. Industry or business

FATHER
12. Name Charles Achstetter
13. Birthplace Germany

MOTHER
14. Maiden Name Josephine Zehr
15. Birthplace Germany

16 (a) Informant Rev. Edwin A. DeLawder
(b) Address 2801 N. Charles street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/26/45 (month) (day) (year)
(c) Cemetery or crematory St. Mary's
Location Washington, D.C.

18 (a) Funeral director Chas. L. Evans-Sons Inc
(b) Address 118 W. Mt. Royal Ave

19 (a) NOV 24 1945 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION R.

20. DATE OF DEATH NOV 23 1945 19__, at 12.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from MAY 28 19 45 to NOV 23 1945, and that I last saw him alive on NOV 23 19 45.

Immediate cause of death	Duration
ANTERIOR CORONARY THROMBOSIS AUGUST 23.	1945
Due to ARTERIOR SCLEROSIS	1945.
Due to CHRONIC MYOCARDITIS	1945.
Other Conditions DIABETIS MELLITUS (Include pregnancy within three months of death)	

Date of operation NONE
Major findings of operation: NONE
of autopsy: NONE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edwin A. DeLawder
Address 3013 ST PAUL STREET Date signed NOVEMBER 26 1945

935

G34121

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183a

G34121 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1615 McElderry
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-5
(e) Length of stay in Baltimore (yrs., mos., or days) 35yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1615 McElderry Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Foster

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	col	married

6 (b) Name of husband or wife Lillian
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) X 1887

8. AGE: Years	Months	Days	If less than one day
58			hr. min.

9. Birthplace Farmville, Va
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Charles Foster Sr.
13. Birthplace Farmville, Va

MOTHER
14. Maiden Name Dolly Fowler
15. Birthplace Farmville, Va

16 (a) Informant John Foster
(b) Address 1728 Orleans St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 24 45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Brooklyn Md

18 (a) Funeral director Elroy O Wilson
(b) Address 1000 Stanley Ave

19 (a) NOV 24 1945 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION 45

20. DATE OF DEATH Nov 16 1945, at 9 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 10 1945 to Nov 16 1945 and that I last saw h[illegible] alive on Nov 13 1945.

Immediate cause of death Apoplexy — Duration 34 days

Due to Arteriosclerosis

Due to Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Edward Fisher M. D.
Address 16 E Edmondson Ave Date signed 11-16-45

Huntington Williams, M.D.

X

46

G34-122

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. G34-122

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3yrs-3mos-18days
(e) Length of stay in Baltimore (yrs., mos., or days) 25 or 26yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town) 2
(d) Street No. 849 West Franklin St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Mary Davis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Virgil Davis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 12-1899

8. AGE: Years 46 | Months 4 3 | Days 8 | If less than one day hr. min.

9. Birthplace N.C. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Washington Magette
13. Birthplace N.C.

MOTHER
14. Maiden Name Annie ?
15. Birthplace N.C.

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-24-45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Brooklyn Md

18 (a) Funeral director Elroy O. Wilson
(b) Address 2410 Beverly ave

19 (a) (Date rec'd by registrar) (b) Registrar

NOV 27 1945

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 20- 1945, at 4.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-2- 1942 to 11-20 1945 and that I last saw h er alive on 11-20- 1945

Immediate cause of death: Cerebral Hemorrhage — Duration:

Due to: Hypertensive Cardiovascular Disease

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation: none

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature T. P. Jernigan M. D.
Address Baltimore City Hosp. Date signed 11-21-45

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34423
CHK-53074

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1945

G34423
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7- 6- 18
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 522 S. Curley Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ~~Gustav Schady~~ Augustav Robert Schady

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Mary -
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 17-1854

8. AGE: Years	Months	Days	If less than one day
91	4	5	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Ferdinand Schady
13. Birthplace ? Germany

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof 11-26-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Rd.

19 (a) (b)
(Signature of local registrar)

NOV 24 1945
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 22 19 45 at 8:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 4 1930, to Nov. 22 1945, and that I last saw h im alive on Nov. 22 1945.

Immediate cause of death Cardiac insufficiency — Duration
Due to Arteriosclerotic heart disease
Due to Benign Prostatic Hypertrophy Chronic cystitis 2 years.
Other Conditions Cerebral Thrombosis Lt. mid cerebral Internal Hydrocephalus
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Cancer

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. Woodward M. D.
Address Baltimore Date signed 11-23-45

X

G34424 G34424

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1000 Eaton Avenue
(c) Hospital or institution: Jenkins Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 Mos.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State D. C. (b) County
(c) City or town Washington (If outside city or town limits, write RURAL and give town)
(d) Street No. 2810- 0 St. S. E. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) **FULL NAME** Flora Mary Denges

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband ~~or wife~~ Henry J. Denges | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 26, 1866

8. AGE: Years 79 | Months 7 | Days 29 | If less than one day hr. min.

9. Birthplace New York - Rochester (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Jacob Weber
13. Birthplace Germany

MOTHER
14. Maiden Name Regina Weigert
15. Birthplace Germany

16 (a) Informant Rev. Joseph F. Denges
(b) Address Issue, Charles Co., Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-27-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Leonard J. Keuck
(b) Address 5 Harford Rd.

19 (a) NOV 24 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 24 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19.

	Duration
Immediate cause of death: Overwhelming Toxemia & Malnutrition	
Due to: Bilateral Bronchopneumonia both lower lobes.	
Due to: Arteriosclerotic Hypertension. C-V Dis.	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thos. B. Carr Jr. M.D.
Address 5 Agnes Hosp. Date signed 11/24/45

VS 250

G34425 G34425

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1310 Bruce St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1310 Bruce St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Della Blake

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: James Claggett

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 25, 1902

8. AGE: Years 42 | Months 10 | Days 28 | If less than one day ... hr. ... min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name George Blake
13. Birthplace Md

MOTHER
14. Maiden Name Agnes Penn
15. Birthplace Md

16 (a) Informant Helen Sommerville
(b) Address 1310 Bruce St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/26/45 (month) (day) (year)
(c) Cemetery or crematory St Peters
Location Md

18 (a) Funeral director Geo. H. Kelson
(b) Address 1303 Presstman St

19 (a) ... (b) ... (Date received by Registrar) Registrar

NOV 24 1945

Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 22 1945, at 11:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 20 1945, to Nov 22 1945, and that I last saw her alive on Nov 22 1945.

Immediate cause of death: Cardio Vascular Disease — Duration: 6 months

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. Wallace Frey M.D.
Address 1928 Penna Ave Date signed 11-24-45

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34426

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G34426 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1007 S.Clinton St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2 6-11

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1007 S.Clinton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

/

3 (a) FULL NAME August J.Burkart

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife Walburga F.Streibig
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan.15,1856

8. AGE:	Years	Months	Days	If less than one day
	89	10	5	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name not known
13. Birthplace Germany

MOTHER
14. Maiden Name not known
15. Birthplace Germany

16 (a) Informant Mrs. Katherine Andrews
(b) Address 1007 S.Clinton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/24/45 (month) (day) (year)
(c) Cemetery or crematory Schwartzs
Location O'Donnell St.

18 (a) Funeral director Clarence F.Hoffmann
(b) Address 1639 N.Broadway

19 (a) (Address of city registrar) (b) Huntington Williams, M.D. (Registrar)

NOV 24 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/20 1945, at 4:45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/9 1945 to 11/20/ 1945 and that I last saw h[illegible] alive on 11/19 1945

Immediate cause of death: Pneumonia (Bronchial) — Duration: 4 days
Pneumonia Arteriosclerosis
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. F. Kuntzmann M. D.
Address 1076 S. East Ave Date signed X 11/23/45

G34427 G34427

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2803 Garrison Blvd.
(c) Hospital or institution: Garrison Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 7 mo

2. USUAL RESIDENCE OF DECEASED:
(a) State Penna. (b) County York.
(c) City or town Hanover Pa.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 316 East Walnut
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna M. Stitt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) ~~Single, married~~, widowed, ~~divorced~~.

6 (b) Name of husband ~~or wife~~ Clifton J. Stitt deceased | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 20 1867

8. AGE: Years 78 | Months 10 | Days 4 | If less than one day hr. min.

9. Birthplace Hanover, Pa.
(Town, county, and state)

10. Usual Occupation Home wife

11. Industry or business

FATHER
12. Name Leo Maurath
13. Birthplace Hanover Pa.

MOTHER
14. Maiden Name Mary M. Miller
15. Birthplace Germany

16 (a) Informant E. M. Stitt
(b) Address 2604 Allendale

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 26 1945 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Hanover, Pa.

18 (a) Funeral director W. A. Fenew
(b) Address Hanover Pa.

19 (a) Date received by Registrar NOV 24 1945 (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 24 1945, at 2 30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 21 1945 to Nov. 24 1945 and that I last saw h~~e~~r alive on Nov 21 1945

Immediate cause of death	Duration
Myocarditis	1 mo.
Due to uterus-sclerosis	?
Due to Hypertension	about 2 years
Other Conditions Acute nephritis	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Harold S. Tibbitt M. D.
Address 220 Harrison Date signed Nov 24/45 Blvd

VS 150

G34428 G34428

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V160C

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md. (b) County a.a. co.
(c) City or town Jacobsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. Mountain Road.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Hess. (BABY WILLIAM DALLAS HESS)

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male.	White.	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-20-45

8. AGE: Years	Months	Days	If less than one day
		3	hr. min.

9. Birthplace Balto. md.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER 12. Name Emory W Hess
13. Birthplace Balto. md.
MOTHER 14. Maiden Name Catherine Krauss
15. Birthplace Balto. md.

16 (a) Informant Friends.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 11/24/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 24 1945 (b) Lexington Williams M.D.
(Date received by registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 23 1945, at 9.35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 20 1945, to Nov. 23 1945, and that I last saw him alive on Nov. 23 1945.

Immediate cause of death	Duration
respirations Ceased	
Due to ? Birth injury	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. M. Morrison, Jr. M. D.
Address Johns Hopkins Hosp. Date signed 11/23/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34429

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1938

G34429 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Church Home & Hosp
(c) Hospital or institution: Youth Brownsville
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 days
(e) Length of stay in Baltimore (yrs., mos., or days) 24 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Penna. (b) County
(c) City or town Greensburg Pa.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1233 Elm Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Jessie Furin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 23, 1909

8. AGE: Years	Months	Days	If less than one day
36	6	1	hr. min.

9. Birthplace Greensburg, Penna.
(Town, county, and state)
10. Usual Occupation housework
11. Industry or business

FATHER
12. Name Mr. Hugh Campbell
13. Birthplace Scotland

MOTHER
14. Maiden Name Jessie Cunningham
15. Birthplace Scotland

16 (a) Informant Church Home
(b) Address Baltimore Md

17 (a) Removal (b) Date thereof Nov. 23/43
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Greensburg, Pa.

18 (a) Funeral director Wm J. Tighe & Sons
(b) Address Baltimore, Md.

19 (a) (b)
(Date rec'd by registrar) Registrar

NOV 24 1943 Huntington Williams, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH November 24 1943, at 9 05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 5 1943, to Nov 24 1943, and that I last saw h.. alive on Nov 24 1943

Immediate cause of death	Duration
Respiratory failure	
due to Uremia Due to	
Chronic Hemorrhagic	
Nephritis, Hypertension	
Due to C-V-I Disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 11/12/43 11/24/43

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles R Heyser M. D.
Address Church Home & Hospital Date signed 11/24/43

G34430

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G34430 Registered No.

correct age is especially important. Physicians: please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 864 N. Fayette St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Samuel B. Cole

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mabel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 27, 1914

8. AGE: Years 31 | Months 8 | Days 24 | If less than one day hr. min.

9. Birthplace Wilmington, N. C. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Arthur Cole
13. Birthplace Elmore, N. C.

MOTHER 14. Maiden Name Mary Lovett
15. Birthplace Pender Co. N. C.

16 (a) Informant Mrs. Mabel Cole
(b) Address 864 N. Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 25, 1945 (month) (day) (year)
(c) Cemetery or crematory Elmore, N. C.
Location

18 (a) Funeral director Mrs. Fred H. Hall
(b) Address 1631 Druid Hill Ave. Baltimore, Md.

19 NOV 24 1945 (b) Huntington Williams, M.D. Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 21 1945, at 7:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 11 1945 to Nov 21 1945, and that I last saw him alive on Nov 21 1945.

	Duration
Immediate cause of death Anoxia	
Due to Pulmonary Embolism	
Due to	
Other Conditions Decubitus ulcer	over

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James R. McHenry Jr. M.D. M. D.
Address University Hosp. Date signed 11/22/45

G34431

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G34431

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2802 Ulman Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town BAltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2802 Ulman Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Abramson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Late William

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years 70 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business House Work

FATHER
12. Name Abraham Legum
13. Birthplace Russia

MOTHER
14. Maiden Name Anna Balser
15. Birthplace Russia

16 (a) Informant Archie Abramson
(b) Address 2802 Ulman Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 25, 1945 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship Cem
Location E Baltimore St

18 (a) Funeral director Sol Levinson & Bros
(b) Address 11241126 W North Ave

(a) Filed 1945 (b) (Rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION 12,30

20. DATE OF DEATH November 24 1945, at P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Novemb 1935 to Nov. 24 1945, and that I last saw h. alive on Nov. 22 1945.

Immediate cause of death	Duration
Cerebral Hemorrhage	2 days
Due to Hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel Epstein M.D.
Address 126 E Mad Date signed 11/27/45

Huntington Williams, M.D.

X

G34432 BALTIMORE CITY HEALTH DEPARTMENT G34432
G34432 CERTIFICATE OF DEATH 50 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address North Broadway
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 28 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County Montgomery
(c) City or town Silver Spring (If outside city or town limits, write RURAL, and give town)
(d) Street No. 9519 Brice Blvd (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Marie Kaufmann

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
f	w	married

6 (b) Name of husband or wife Mr. Forman R.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 5, 1897

8. AGE: Years	Months	Days	If less than one day
46	6	19	hr. min.

9. Birthplace Missouri (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name John Mosier
13. Birthplace Holland.

MOTHER
14. Maiden Name Magdelena Schneider
15. Birthplace Holland

16 (a) Informant
(b) Address

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11-25-45 (month) (day) (year)
(c) Cemetery or crematory
Location Silver Spring Maryland
18 (a) Funeral director Harnel E. Humphrey
(b) Address 8434 Ga ave Silver Spring Md
19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 24 1945 at 11:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 24 1945 to Nov 24 1945 and that I last saw h.. alive on Nov 24 1945.

Immediate cause of death	Duration
respiratory failure	
Due to metastatic Carcinoma to lung center	
Due to Sq. Cell Ca of Left breast	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 10/29/45
Major findings of operation: Sq cell ca left breast
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Phyllis R Augustin M. D.
Address Church Home & Hosp Date signed

VS 150

G34433 ✓ G34433

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 137a

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital 6-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 44 days
(e) Length of stay in Baltimore (yrs., mos., or days) Unknown

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4 N. Chester St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** BENJAMIN LEWIS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, ~~married, widowed, or divorced.~~
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years	Months	Days	If less than one day
73			hr. min.

9. Birthplace Russia
(Town, county, and state)
10. Usual Occupation Pants presser
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace R.

MOTHER
14. Maiden Name Unknown
15. Birthplace Russia

16 (a) Informant Hosp.
(b) Address

17 (a) Burial (b) Date thereof 11-25-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Heritage Mt. Carmel
Location Jack Levine Inc 1439 E. Baltimore St

18 (a) Funeral director
(b) Address

19 (a) NOV 23 1945 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

NOV 25 1945

MEDICAL CERTIFICATION

20. **DATE OF DEATH** Nov 24 1945, at 3.00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 4 1945, to Nov 24 1945, and that I last saw h[illegible] alive on Nov 24 1945.

Immediate cause of death Myocardial insufficiency

Duration

Due to Occlusion Anterior Coronary artery.

Due to

Other Conditions Ileus secondary to peritonitis

(Include pregnancy within 3 months of death)

Date of operation Nov 2, 1945

Major findings of operation: Benign hypertrophy prostate

of autopsy: Myocardial infarctions

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. **Signature** Louis N. Jaskin M. D.

Address Sinai Hospital Date signed 11/24/45

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34434

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

160a

G3[illegible] Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette + Calhoun Sts. Balt 23
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 15, md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 4109 Belle Ave. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Creasel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Single

6 (b) Name of husband or wife None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 19, 1945

8. AGE: Years	Months	Days	If less than one day
		5	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and State)

10. Usual Occupation None

11. Industry or business None

FATHER
12. Name Alfred Creasel
13. Birthplace Houston, Texas

MOTHER
14. Maiden Name Shirley Feit
15. Birthplace Baltimore, Md.

16 (a) Informant Shirley Creasel
(b) Address 4109 Belle Ave, Balt, md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-25-45 (month) (day) (year)
(c) Cemetery or crematory Greenlawn
Location Park Rd + Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Baltimore St

19 (a) NOV 27 1945 Huntington Williams, M.D. (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 24 1945, at 5:30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 19 1945, to Nov 24 1945, and that I last saw h[illegible] alive on Nov 24 1945.

Immediate cause of death	Duration
Cerebral Hemorrhage	5 days.
Due to Prematurity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Goldenberg

Address 2326 Eutaw Pl Date signed 11/26/45 M. D.

X

G34435 BALTIMORE CITY HEALTH DEPARTMENT G34435
CERTIFICATE OF DEATH 93c Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4029 Park Heights Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 46 yrs -

2. USUAL RESIDENCE OF DEACEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 4029 Pk. Hgts Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Pear

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Isaac Pear

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) [illegible]71

8. AGE: Years 74 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Ben Petzer

13. Birthplace Russia

MOTHER 14. Maiden Name Mary —

15. Birthplace Russia

16 (a) Informant Mrs. Rose Blumberg

(b) Address 4029 Pk. Hgts. Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-25-45 (month) (day) (year)

(c) Cemetery or crematory Rosedale

Location

18 (a) Funeral director Jack Levin Inc

(b) Address 1739 E. Balto St

19 (a) NOV 25 1945 (Date rec'd by registrar) (b) Huntington Ave Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 23- 1945, at 10 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 15 1945, to Nov 23 1945, and that I last saw her alive on Nov 23 1945.

Immediate cause of death Pulmonary Edema — Duration A few mins.

Due to R Rheumatic Heart D. and Arteriosclerosis H. D.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis V. Blum, M. D.

Address 2300 Eutaw Pl. Date signed 11/28/45

M. D.

VS 150

G34436

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G34436 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2303 Troga Pkwy
(c) Hospital or institution: 11

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2303 Troga Pkwy
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DANIEL COHEN

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6 (b) Name of husband or wife SADIE
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1891

8. AGE: Years	Months	Days	If less than one day
54			hr. min.

9. Birthplace POLAND (Town, county, and state)
10. Usual Occupation SHOE REPAIR
11. Industry or business

FATHER
12. Name ISRAEL
13. Birthplace POLAND

MOTHER
14. Maiden Name PEARL
15. Birthplace POLAND

16 (a) Informant WIFE
(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 11-25-45 (month) (day) (year)
(c) Cemetery or crematory SHAAREI TFILOH
Location WINDSOR MILL RD

18 (a) Funeral director JACK LEWIS INC
(b) Address 1439 E. BALTO. ST

25 1945
(Date rec'd by registrar) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-24 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/23 1945, to 11/24 1945, and that I last saw him alive on 11/23 1945.

Immediate cause of death	Duration
Coronary Thrombosis	1 hour
Congestive Pneumonia	
Due to	
Due to	
Other Conditions Diabetes Mellitus	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Sol Smith
Address 1223 E. Monk Ave. Date signed M. 11/24/45 D.

94a

G34437

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G34437 Registered No. 131a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1121 N. Bradford St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 4
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1121 N. Bradford St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Hotem

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Henry W. Hotem

6 (c) If dive, give age years

7. Birth date of deceased (mo., day, yr.) May 2 - 1884

8. AGE: Years 61 | Months 6 | Days 21 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Frank Hinkleman
13. Birthplace Baltimore

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Henry W. Hotem
(b) Address 1129 N. Bradford St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 27 45 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Philip Herwig Sons
(b) Address 2024 Orleans st

NOV 25 1945 (Date received by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 23 1945, at 9.55 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 16 1945 to Nov. 23 1945, and that I last saw he alive on Nov 23 1945.

Immediate cause of death Decompensating cardiac - renal vascular disease — Duration 2 yrs +

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Boyd Edwards M. D.
Address 1101 N. Wheaton Ave Date signed 11-24-45

VS 150

G34438 G34438

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1108

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 661 W Fayette St
(If rural route location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Sumption

3 (b) If veteran, name war: ,

3 (c) Social Security Account No. 215-03-1798

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	Married

6 (b) Name of husband or wife Helen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1897

8. AGE: Years	Months	Days	If less than one day
48			hr. min.

9. Birthplace Winchester, VA.
(Town, county, and state)
10. Usual Occupation Police Guard
11. Industry or business

FATHER
12. Name ?
13. Birthplace VA.

MOTHER
14. Maiden Name ?
15. Birthplace VA.

16 (a) Informant Helen Sumption
(b) Address 661 W Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 27 45 (month) (day) (year)
(c) Cemetery or crematory Mount Hebron.
Location Winchester, VA

18 (a) Funeral director Joseph Kasinskas Jr
(b) Address 602 Washington Blvd
(Date received by local registrar) NOV 25 1945 (b) Huntington Williams Md

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/24/45 19 12:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/21 19 45 to 11/24 19 45, and that I last saw him alive on 11/24 19 45.

Immediate cause of death	Duration
Congestive heart failure	
Due to Rheumatic Heart Disease	
Due to	
Other Conditions Pneumonia Right lower lobe - etiology unknown	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Richard J. Lhunn M.D.

Address Date signed

95 B

G34439

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G34439 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4802 Edgar Terrace
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4802 Edgar Terrace
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosina Cramblett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Stephen Cramblett

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 22 1852

8. AGE: Years 93 | Months 6 | Days 2 | If less than one day hr. min.

9. Birthplace Prince George Co Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business At Home

FATHER
12. Name Sommer
13. Birthplace Md

MOTHER
14. Maiden Name Dont Know
15. Birthplace Md

16 (a) Informant Harry Cramblett
(b) Address 4802 Edgar Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 26 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville

18 (a) Funeral director Leerist Funeral Home
(b) Address 2004 E. Allen

25 1945 (Date received by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 25 1945, at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 10 1944 to Dec 25 1945 and that I last saw HER alive on Dec 24 1945.

Immediate cause of death: Arteriosclerosis
Heart Disease — Duration: 5 years
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo Sommer M. D.
Address 4808 Harford Rd Date signed 11/25/45

G34440

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √50

G34440 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1601 Pulworth Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town 1601 Pulworth Road
(If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore Md.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna L. Schluderberg

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 29 1879

8. AGE: Years 66 | Months — | Days 24 | If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER 12. Name Henry Schluderberg

13. Birthplace Germany

MOTHER 14. Maiden Name Louisa Hoff

15. Birthplace Germany

16 (a) Informant Henry Schluderberg

(b) Address 3211 Tyndale Ave

17 (a) Burial (b) Date thereof Nov 26th
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Oak Lawn Cem
Location City

18 (a) Funeral director Uelrich Funeral Home

(b) Address 2104 E. Orleans St.

19 (a) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

N 25 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 22 1945; at 10 45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 2 1945 to Nov 22 1945. and that I last saw her alive on Nov 21 1945.

Immediate cause of death Cerebral Thrombosis | Duration 1 day

Due to arteriosclerosis.

Due to

Other Conditions carcinoma R. Breast.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo. W. DeHoff

Address 2020 N. Charles Date signed 11/23/45

Geo. W. DeHoff

G34441

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G34441
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2m
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Roxton - Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Elisa Knapp

3 (b) If veteran, name war –
3 (c) Social Security Account No. –

4. Sex: F.
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: single
6 (b) Name of husband or wife: –
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Aug - 13 - 1876
8. AGE: Years 69 | Months 3 | Days 12 | If less than one day hr. min.
9. Birthplace Conn - USA (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Ezra Knapp
13. Birthplace Conn - USA

MOTHER
14. Maiden Name Sarah L Meeker
15. Birthplace Virginia - USA

16 (a) Informant (Mrs) Sarah Joyce - sister
(b) Address Roxton - Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 27, 1945 (month) (day) (year)
(c) Cemetery or crematory Centre
Location Bethel, Conn.

18 (a) Funeral director Wm. J. Tickner & Sons.
(b) Address North & Penna. Aves.

19 (a) Received by registrar (b) Huntington Williams, M.D. Registrar

NOV 29 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov - 25 - 1945, at 4:25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov - 23 - 1945, to Nov - 25 1945, and that I last saw h.er alive on Nov - 24 1945

Immediate cause of death	Duration
Cerebro - Vascular Accident	
Due to Hypertensive Cardio-Vascular Disease	
Due to	
Other Conditions Diabetes	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Huntington Williams M.D.
Address Union Memorial Hosp. Date signed 11/29/45

927

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

G34442

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

G34442 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 345 EAST 29th STREET.
(c) Hospital or institution:
NONE
(d) Length of stay in hospital or inst. (yrs., mos., or days) NONE
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE.

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town CITY BALTIMORE.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 345 EAST 29th STREET. (If rural route, location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME NETTIE VIRGINIA WHEELER.

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Elmer E. Wheeler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 31, 1866

8. AGE: Years	Months	Days	If less than one day
78	10	23	hr. min.

9. Birthplace Denton, Md. (Town, county, and state)
10. Usual Occupatien None
11. Industry or business

FATHER
12. Name Gootee Stevens
13. Birthplace Md.

MOTHER
14. Maiden Name Virginia Willis
15. Birthplace Md.

16 (a) Informant Mr. William U. Wheeler
(b) Address 430 Kenneth Square

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/26/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Wm. J. Tickner & Sons, Inc.
(b) Address North & Pennsylvania Aves.

19 (a) 1945 (Filled in by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION A.

20. DATE OF DEATH NOVEMBER 24 1945, at 3.10 M

21. I certify that death occurred on the date above stated; that I attended deceased from NOV 23 1945 to NOV 24 1945, and that I last saw her alive on NOV 24 1945.

	Duration
Immediate cause of death APOPLEXY NOVEMBER 23	1945.
Due to ARTERIOR SCLEROSIS.	1945
Due to CHRONIC MYOCARDITIS	1945.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation NONE
Major findings of operation: NONE
of autopsy: NONE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lewis P. Clanton
3013 ST PAUL ST NOVEMBER 24 1945
Address Date signed

X

G31443

CWK-94772

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G31443 Registered No. 1313

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0- 4- 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 6 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1231 N. Caroline Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ophelia Lomax

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife James Lomax
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 11-1909

8. AGE: Years	Months	Days	If less than one day
36	2	12	hr. min.

9. Birthplace Virginia
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Lonnie Lawrence
13. Birthplace Virginia

MOTHER
14. Maiden Name Nannie Warren
15. Birthplace Virginia

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 11-25-45 (month) (day) (year)
(c) Cemetery or crematory Windsor Va
Location Windsor Virginia
18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St
19 (a) (Signature of registrar) (b) Huntington Williams, M.D.

NOV 23 1945

VS 150

MEDICAL CERTIFICATION

P

20. DATE OF DEATH November 23 1945, at 5:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 16 1945, to Nov. 23 1945, and that I last saw her alive on Nov. 23 1945

Immediate cause of death Pulmonary Tuberculosis — Duration 2

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert B. Copeland Jr. M.D.
Address Balt. City Hosp. Date signed 11/24/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34444

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G34444 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1817 Guilford Avenue
(c) Hospital or institution:

12

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1807 Guilford Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNIE OTIS BOWIE

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Edmund C. Bowie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name UNKNOWN
13. Birthplace

MOTHER
14. Maiden Name UNKOWN
15. Birthplace

16 (a) Informant Mr. Edmund Bowie, Jr.
(b) Address 1817 Guilford Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-27-45 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem
Location City

18 (a) Funeral director [illegible]
(b) Address [illegible]

19 (a) NOV 28 1945 (Date filed) (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 25th 1945 at 8:00A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 20 1945 to Nov 26 1945 and that I last saw h[illegible] alive on Nov 22 1945

Immediate cause of death	Duration
Acute Coronary	
Due to Occlusion	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature L. J. Sturby M.D.
Address 110 E. North Ave. Date signed 11/29/45

X

G34445

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 137a

Registered No. G34445

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution:
South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) 51 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 926 S. Conklin St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME: Joseph Lewandowski

3 (b) If veteran, name war: ----

3 (c) Social Security Account No. 217-05-2047

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/13/1873

8. AGE: Years 72 | Months 8 | Days 8 | If less than one day ... hr. ... min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation Watchman

11. Industry or business Canning Industry

FATHER
12. Name Joseph Lewandowski
13. Birthplace Poland

MOTHER
14. Maiden Name ------ Lewandowski
15. Birthplace Poland

16 (a) Informant Unknown
(b) Address Poland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/26/45 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Mt. Carmel Road

18 (a) Funeral director M. J. Sadowski & Son
(b) Address 1808 Eastern Ave

19 (a) ... (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

NOV 26 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH November 21, 1945, at 12:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/9/45 19..., to 11/21/1945, and that I last saw him alive on 11/21 19 45.

Immediate cause of death	Duration
Shock	2 Hrs
Due to Secondary Hemorrhage	24 Hrs
Due to	
Other Conditions Benign Prostatic Hypertrophy	6 Mos

(Include pregnancy within 3 months of death)

Date of operation Nov. 21, 1945

Major findings of operation: Benign Prostatic Hypertrophy

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John M. Blenkin M.D.
Address 1213 Light St. Date signed 11/26/1945

Mary X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634446

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No. 634446

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 301 Calverton Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 301 Calverton Road
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Sister Mary of St. Bernard (Wilkens)

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife:
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) January 28, 1866

8. AGE: Years 79 | Months 9 | Days 28 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Sister of the Good Shepherd
11. Industry or business

FATHER
12. Name Henry Garrett Wilkens
13. Birthplace Germany

MOTHER
14. Maiden Name Helen Bernadine Bokel
15. Birthplace Germany

16 (a) Informant Sister Mary Fiddis
(b) Address 301 Calverton Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-26-45 (month) (day) (year)
(c) Cemetery or crematory Mount Cathedral
Location Baltimore, Maryland

18 (a) Funeral director George L. Schwab
(b) Address 2101 Frederick Ave.

Date received NOV 26 1945 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 25, 1945, at 5:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/23 1945, to 11/25 1945, and that I last saw h[illegible] alive on 11/24 1945.

	Duration
Immediate cause of death: Cerebral hemorrhage due to arteriosclerosis + failure	10 Hours
Due to: chronic myocarditis	
Due to: myocardial degeneration + chronic nephritis	10 years
Other Conditions: —	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Otis F. Thomas M. D.
Address 804 Cathedral St. Date signed 11/26/45

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34447

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 E

Registered No. G34447

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address North Broadway
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) 14 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Virginia (b) County Accomack
(c) City or town Chincoteague
(If outside city or town limits, write RURAL and give town)
(d) Street No. 335 S. Main Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Fred Bowden

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No.:

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mrs. Marion Bowden
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1, 1894

8. AGE: Years 51 | Months 8 | Days 24 | If less than one day ... hr. ... min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Poultry raiser
11. Industry or business

FATHER
12. Name Joseph Bowden
13. Birthplace Virginia

MOTHER
14. Maiden Name Annie Steelman
15. Birthplace New Jersey

16 (a) Informant Mrs Marion Bowden
(b) Address Chincoteague Va

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Nov 25/45 (month) (day) (year)
(c) Cemetery or crematory Greenwood Cemetery
Location Va

18 (a) Funeral director William Cook Inc
(b) Address 127 E. Race St. Pennington Williams, Md.

19 (a) NOV 26 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 25 1945, at 11:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 9 1945 to Nov 25 1945 and that I last saw him alive on Nov 25th 1945

	Duration
Immediate cause of death: respiratory failure	
Due to: acute perforated peritonitis	
Due to: infection at site of previous operation	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation 11/19/45
Major findings of operation: Ca of Splenic flexure
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Phyllis R Ingram M. D.
Address Church Home Date signed 11/26/45

X & Harp

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34448

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH /338

Registered No. G34448

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk & 31st.
(c) Hospital or institution:
U.S. Marine Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Mo
(e) Length of stay in Baltimore (yrs., mos., or days) 2 Mo

2. USUAL RESIDENCE OF DECEASED:
(a) State Va (b) County Norfolk
(c) City or town Norfolk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 104 W 29th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Vivian Mae Farrell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 8, 1899

8. AGE: Years	Months	Days	If less than one day
46	8	17	hr. min.

9. Birthplace Gregory, Mich
(Town, county, and state)

10. Usual Occupation Nurse

11. Industry or business

FATHER
12. Name Thomas Farrell
13. Birthplace Gregory Mich

MOTHER
14. Maiden Name Lottie Hemingway
15. Birthplace Gregory Mich

16 (a) Informant
(b) Address Hospital Records

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11/25/45 (month) (day) (year)
(c) Cemetery or crematory
Location Norfolk Va.

18 (a) Funeral director Wm. J. Tickner & sons
(b) Address North & Pa. Aves

NOV 26 1945

19 (a) (Date rec'd by registrar) (b) Huntington-Williamsport, Md. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-25-45 19 , at 11 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-25 1945 to 11-25-1945, and that I last saw h.e.r alive on 11-25-1945

Immediate cause of death	Duration
Uremia	3mo
Due to Bilat cystic kidneys	4yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature L R Baker M. D.

Address U.S. Marine Hosp. Date signed 11-25-45

X

G34449

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G34449

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts.
(c) Hospital or institution:
Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1400 Linden Ave.
(If rural give location)
(e) Citizen of foreign country? [illegible] (Yes or No)
If yes, name country

3 (a) **FULL NAME** Robert L Watkins

3 (b) If veteran, name war: 10
3 (c) Social Security Account No.: [illegible]

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower
6 (b) Name of husband or wife: Annie A
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 13 1869

8. AGE: Years 76 | Months 5 | Days 11 | If less than one day ..... hr. ..... min.

9. Birthplace Manson, Warren Co. N. C.
(Town, county, and state)

10. Usual Occupation [illegible]

11. Industry or business

FATHER
12. Name Thomas M Watkins
13. Birthplace South Carolina

MOTHER
14. Maiden Name Susan Johnson
15. Birthplace Virginia

16 (a) Informant Sue D Watkins
(b) Address Sanford North Carolina

17 (a) Burial, cremation, or removal (b) Date thereof 11/29/45 (month) (day) (year)
(c) Cemetery or crematory Middleburg
Location Vance Co. N. C.

18 (a) Funeral director Wilson Cook Inc.
(b) Address 129 E Lane St

19 NOV 26 1945 Raleigh Williams, M.D.
(Registrar's signature)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 24 1945, at 8:57 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 24 1945 to Nov 24 1945, and that I last saw him alive on Nov 24 1945

Immediate cause of death	Duration
Arteriosclerotic heart disease	
Due to Arteriosclerosis, general	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. D. Speed III M. D.
Address Union Memorial Hospital Date signed 11-27-45

G34450

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G34450

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2793 Tivoly Ave
(c) Hospital or institution: qr

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2793 Tivoly Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Jane Wilkinson

3 (b) If veteran, name war: W
3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Alexander
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 11 1862

8. AGE: Years	Months	Days	If less than one day
83	0	11 12	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Frederick White
13. Birthplace Germany

MOTHER
14. Maiden Name Emma Turnbull
15. Birthplace Baltimore Md

16 (a) Informant Raymond Wilkinson
(b) Address 2793 Tivoly Ave

17 (a) Burial (b) Date thereof 11/27/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Laphams
Location Forestdale Md

18 (a) Funeral director Wilson Undertaking Co
(b) Address 1217 E Fort Ave

19 (a) NOV 26 1945 (b) Hunter for Williams, M.D.
(Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 24 1945, at 8 15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 2 1945, to Nov 24 1945
and that I last saw h alive on Nov 23 1945

Immediate cause of death
Cardiac decompensation — Duration: Nov 18 1945

Due to

Due to

Other Conditions Chronic Myocarditis (arterio-Sclerosis) — Duration: a number of years
(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas B. Green M. D.
Address 3009 Evergreen ave Date signed Nov 25/45
Baltimore 14 - Maryland

G34451

AB-97340

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30 E

Registered No. G34451

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7days
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1204 Harford Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Peter J. Beardsworth

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: ?

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Bessie Irene
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 24-1882

8. AGE: Years 63 | Months 1 | Days 29 | If less than one day ... hr. ... min.

9. Birthplace Hoboken, N.J.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name John Beardsworth
13. Birthplace England

MOTHER
14. Maiden Name Margaret Nolan
15. Birthplace Ireland

16 (a) Informant Baltimore City Hospitals (Record)
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/27/45 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Parkville Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul st

NOV 26 1945
(Local Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 23- 19 45 at 11.25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-16 19 45 to 11-23 19 45, and that I last saw h im alive on 11-23- 19 45

Immediate cause of death Syphilitic heart disease — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jonathan Howland M. D.
Address B. C. H. Date signed 11/24/45

G34452
AB- 97348

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G34452

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 712 E. Chase St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William R. Blessing

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: None

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Mary Elizabeth
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 21- 1865

8. AGE: Years	Months	Days	If less than one day
80	3	4	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Farm Loyd
11. Industry or business

FATHER
12. Name Ferdinand Blessing
13. Birthplace Ireland

MOTHER
14. Maiden Name Kate North
15. Birthplace Scotland

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/28/45 (month) (day) (year)
(c) Cemetery Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1647 St. Paul St.

NOV 26 1945

19 (a) (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 25 1945 at 3.25A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 17 1945, to 11-25- 1945, and that I last saw h. im alive on 11-25- 1945

Immediate cause of death	Duration
cardiac failure	
Due to Arteriosclerotic heart disease and	
Due to hypertension cardio vascular disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jonathan Howland M. D.
Address B.C.H. Date signed 11/25/45

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34453

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92B

G34453 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Bolton Monument & Eutaw
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1 N. Ellamont Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Regina A. Garner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, ~~widowed, or~~ divorced. Married

6 (b) Name of husband or wife Ralph A. Garner

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 19th 1903

8. AGE: Years	Months	Days	If less than one day
42	9	5	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER
12. Name Wm George Broderick
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace Balto. Md.

16 (a) Informant Ralph A. Garner
(b) Address 1 N. Ellamont Ave

17 (a) Burial (Burial, cremation, removal) (b) Date thereof 11/28/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

NOV 26 1945 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-24 1945, at 9:65 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-24 1945 to 11-24 1945, and that I last saw her alive on 11-24 1945.

Immediate cause of death Congestive Heart Failure — Duration

Due to Rheumatic Heart Disease M.I. + M.S.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jerome R. Perlman M. D.
Address Sinai Hospital Date signed 11-24-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34454
337859

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1108

Registered No. G34454

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 17

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Homewood Apts Charles-31st St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lola Brumble

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: none

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife:
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-15-74

8. AGE: Years 71 | Months 8 | Days 10 | If less than one day hr. min.

9. Birthplace Pa. (Pittsburgh)
(Town, county, and state)

10. Usual Occupation
11. Industry or business specialty shop

FATHER
12. Name William Brumble
13. Birthplace Pa.

MOTHER
14. Maiden Name Inez Crandall
15. Birthplace Pa

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 11/27/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 127 St. Paul St

19 NOV 26 1945 (Date received by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 25 - 1945, at 3:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-7-1945 to 11-25-1945 and that I last saw h[illegible] alive on 11-25-1945.

Immediate cause of death	Duration
Exhaustion & Cardiac Failure	
Due to Bronchopneumonia	3 wks
Due to	
Other Conditions ? Pulmonary Embolism Pleural effusion	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Laurence Jackson M.D. M.D.
Address Johns Hopkins Hospital Date signed 11/25/45

G34455

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

FSD ✓

G34455 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5711 Winner Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or townlimits, write RURAL and give town)
(d) Street No. 5711 Winner Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME THOMAS H. CANDLES

3 (b) If veteran, name war W
3 (c) Social Security Account No. none

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of ~~husband~~ or wife Emma L. Candles

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 13th 1872

8. AGE: Years 73 | Months 2 | Days 12 | If less than one day hr. min.

9. Birthplace Balto. Co. Md
(Town, county, and state)

10. Usual Occupation Paper Hanger & Painter

11. Industry or business Self

FATHER
12. Name Charles Candles
13. Birthplace Unknown

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Emma L. Candles
(b) Address 5711 Winner Ave.

17 (a) Burial (b) Date thereof 11/28/45
(Burial, ~~cremation~~, or removal) (month) (day) (year)

(c) Cemetery ~~or crematory~~ Woodlawn
Location " Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St Paul st.

19 (a) NOV 26 1945 (Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/25/45 19 , at 11:00 A M

21. I certify that I took charge of the remains described above, held an Inspection Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Sue death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Devine, M.D.
Medical Examiner.
Date signed 11/25/45

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34456

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G34456

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6000 Dillona Ave
(c) Hospital or institution: Edgewood Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4112 Hutton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Naomi Weigel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan 6 1889

8. AGE: Years 56 | Months 10 | Days 18 | If less than one day: hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Frederick Weigel
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Christine Londoni
15. Birthplace Baltimore Md

16 (a) Informant Elmer R Mosgrove
(b) Address 3360 Hickory Ave

17. Burial (Burial, cremation, or removal) (b) Date thereof 11/27/45 (month) (day) (year)

(c) Cemetery or crematory Woodlawn
Location Baltimore Md

18 (a) Funeral director Hilborn & Son Inc
(b) Address 1217 W Pratt St

19 Date rec'd NOV 26 1945 (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 24 1945, at 2a M

21. I certify that death occurred on the date above stated; that attended deceased from Oct 22 1945 to Nov 27 1945 and that I last saw h[illegible] alive on Nov 24 1945

Immediate cause of death: Paralysis — Duration: 3 months

Due to

Due to Cerebral Hemorrhage

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L A Archondros M.D.

Address 112 W. 39th St Date signed Nov. 25 1945

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34457

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G34457

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Mehrain & Sondheim
(c) Hospital or institution: Maryland General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 7 9

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3633 Oak Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin S. Mister

3 (b) If veteran, name war: no
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~
Male	White	Widowed

6 (b) Name of ~~husband~~ wife Bertha A. Mister
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 15th 1878

8. AGE: Years	Months	Days	If less than one day
67	1	9	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Office Work
11. Industry or business Chesapeake Paper Board Co.

FATHER
12. Name (Unknown) Mister
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Beatrice Mister
(b) Address 3633 Oak Ave

17 (a) Burial (b) Date thereof 11/27/45
(Burial, ~~cremation, removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Moreland
Location Parkwood Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 E. Paul St

19 (~~Signature of~~ Registrar) NOV 26 1945 Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 24 1945 at 2:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 23 1945 to Nov 24 1945 and that I last saw h[illegible] alive on Nov 23 1945

Immediate cause of death	Duration
Cardiac failure	
Due to Hypertensive Cardiovascular disease	
Due to	
Other Conditions Bronchial asthma	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. M. Caulard M. D.
Address Md. Gen. Hosp Baltimore Md. Date signed Nov 26 1945

VS 150

G34458

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 946

Registered No. 631458

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 941 Bond St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Randolph Bradley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 2, 1901

8. AGE: Years	Months	Days	If less than one day
44	4	21	hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Tom Bradley
13. Birthplace Va.

MOTHER
14. Maiden Name Unknown
15. Birthplace Va.

16 (a) Informant Edna Morgan
(b) Address 941 Bond St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-28-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cemetery
Location Md.

18 (a) Funeral director Adolphus Halstead
(b) Address Druid Hill Ave.

19 (a) NOV 26 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 23, 1945, at 5:10 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Haddix M.D.
Medical Examiner.
Date signed 11-24-45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34459

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. G34459

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: University Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 695 W. Mulberry St.
(If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME Jessie J. Dixon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	married

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct. 15, 1901

8. AGE: Years	Months	Days	If less than one day
44	1	6	..... hr. ..... min.

9. Birthplace North Carolina
(Town, county, and state)

10. Usual Occupation Fish man

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Beatrice Bailey
(b) Address 695 W Mulberry st

17 (a) Burial (b) Date thereof 11-30-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location.....

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

19 NOV 26 1945 Huntington Williams M.D
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 24 1945, at..... M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 21 1945 to Nov 24 1945 and that I last saw h.i.m. alive on Nov 21 1945.

Immediate cause of death	Duration
.....	.....
.....	.....
Due to Coron pneumonia - at home	.....
.....	.....
Due to	.....
.....	.....
Other Conditions	.....

(Include pregnancy within 3 months of death)

Date of operation.....
Major findings of operation:.....
.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....

23. Signature J. R. M. Hurd Jr. M.D.
M. D.
Address Union Farm Date signed 11/26/45

VS 3

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

GRAFF

G34460

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

§ 3D ✓

Register's No. 634460

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 606 S. Macon St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) D.U.K.
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 606 S. Macon St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louisa Graff

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	MARRIED

6 (b) Name of husband or wife PHILLIP GRAFF
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APR. 28 1866

8. AGE: Years	Months	Days	If less than one day
79	6	26	hr. min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)
10. Usual Occupation HOUSE WIFE
11. Industry or business AT HOME

FATHER
12. Name MINER
13. Birthplace GER.

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace GER.

16 (a) Informant ELIZABETH YOST (DAUGHTER)
(b) Address 606 S. MACON ST.

17 (a) BURIAL (b) Date thereof NOV. 27/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory SCHWARTZ
Location ODONNELL ST.

18 (a) Funeral director Lilly d Zeiler Inc.
(b) Address 403 S. WOLFE ST.

NOV 26 1945
(Date rec'd by registrar)

(b) Huntington Williams, M.D.
Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/24 1945, at 2:54 P.M.

21. I certify that I took charge of the remains described above, held an Inspection-Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic C.V Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Lubinski M.D.
Medical Examiner.
Date signed 11/26/45

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

631-61

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. 631-61

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 308 S. DUNCAN ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 308 S. DUNCAN ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: ANNA PHILLIPS

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.: NONE

4. Sex: FEMALE

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: WIDOW

6 (b) Name of husband or wife: VALENTINE PHILLIPS

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): MAY 6 1878

8. AGE: Years 67 | Months 6 | Days 17 | If less than one day ... hr. ... min.

9. Birthplace: BALTIMORE MD. (Town, county, and state)

10. Usual Occupation: HOUSE WIFE

11. Industry or business: AT HOME

FATHER
12. Name: ? FISHER
13. Birthplace: BALTO. MD.

MOTHER
14. Maiden Name: UNKNOWN
15. Birthplace: BALTO.

16 (a) Informant: CHARLES PHILLIPS (SON)
(b) Address: 314 S. DUNCAN ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof NOV. 26/45 (month) (day) (year)
(c) Cemetery or crematory: SCHWARTZ
Location: ODONNELL ST.

18 (a) Funeral director: Lilly & Zeiler Inc.
(b) Address: 403 S. WOLFE ST.

19 (a) NOV 26 1945 (Date received by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: NOV. 23 1945, at 8/35 PM.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 20 1945 to Nov. 23 1945, and that I last saw her alive on Nov. 23 1945

Immediate cause of death	Duration
CEREBRAL HEMORRHAGE	11/20/45
Due to: ARTERIAL HYPERTENSION	2 Y.
Due to:	
Other Conditions: TERMINAL BRONCHO-PNEUMONIA	3 DAYS

(Include pregnancy within 3 months of death)

Date of operation: NONE

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Joseph F. Hutzler

Address: 209 Chester Rd. Date signed 11/24/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634462 — BALTIMORE CITY HEALTH DEPARTMENT — Registered No. 634462

TN. 97359

CERTIFICATE OF DEATH 159

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 12 hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 728 W. North Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Beichler (Dorothea

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 18th 1945

8. AGE: Years | Months | Days | If less than one day: 12 Hours hr. min.

9. Birthplace Baltimore , Maryland
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Glenn Riddle
13. Birthplace Mo.

MOTHER
14. Maiden Name Dorothea Beichler
15. Birthplace Pa.

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) 11-23-45 (Burial, cremation, removal) (b) Date thereof 11-23-45 (month) (day) (year)
(c) ~~Cemetery or~~ crematory
Location Balto City Hospitol

18 (a) Funeral director
(b) Address 4940 Eastern Ave Huntington Williams

19 (a) NOV 26 1945 (Date received by Registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 19th. 45 19 10.25 A.M. at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 18, 1945 to Nov. 19 19 45, and that I last saw her alive on Nov 19 th 19 45.

Immediate cause of death	Duration
Aspiration Pneumonia	
Due to	
Due to Prematurity	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Isaac Thees
Address BCH Date signed 11/26/45

G34463

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. G34463

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: South Balto. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D-0-A
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 612 S. Charles Street (If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) **FULL NAME** James Watson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1894

8. AGE: Years 51 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Jacksonville Fla. (Town, county, and state)

10. Usual Occupation Cook

11. Industry or business

FATHER
12. Name Ross Watson
13. Birthplace Fla

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a). Informant Rosie Lumley
(b) Address 612 S. Charles St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-26-45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. A Co. Md.

18 (a) Funeral director Isaac L Brown & Son
(b) Address 102 W Montgomery St

19 (a) NOV 26 1945 (b) Registrar

VS 15

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-14-1945, at 7:35 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute Bacterial Endocarditis

Due to .....

Other Conditions Lobar Pneumonia.
Acute dilatation of Heart
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed 11-15-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Enter the causes of death clearly and legibly. correct age is especially important. Physicians: please write the c

910

G34464 Medical case
Released by Coroner

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 116

Registered No. G34464

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 628 N. Eden St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Kelsey Bailey
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Single.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-24-41.

8. AGE: Years	Months	Days	If less than one day
3	10	22	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Wilbur Jackson.
13. Birthplace Md.

MOTHER 14. Maiden Name Beulah Dorsey.
15. Birthplace Md.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-26-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Brooklyn Md.

18 (a) Funeral director Mrs. Della Risby
(b) Address 1421 E. Jefferson St

NOV 26 1945 (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-23 1945 at 12 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 11-20 1945 to 11-23 1945 and that I last saw h-- alive on 11-23 1945.

Immediate cause of death: Cerebral Necrosis — Duration: 3 days
Due to Anoxia During Anesthesia — 5 minutes
Due to
Other Conditions Perforation of Esophagus
(Include pregnancy within 3 months of death)
Date of operation 11/20/45
Major findings of operation: Perforated Esophagus
of autopsy: Perforated Esophagus.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 11/20/45 at 9 P M
(c) Where did injury occur? Baltimore (City or town) Md. (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Hospital (Specify type of place) While at work?
(e) Means of injury Esophagoscopic examination
23. Signature J. E. Carson III M. D.
Address Johns Hopkins Hospital Date signed 11/29/45

Howard J. Carson, M.O.X

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34465

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G34465 Registered No.

MB 93084

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 9 3
(e) Length of stay in Baltimore (yrs., mos., or days) 65 10 26 Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 118 S. Caroline St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: William Cole

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Mary Cole

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25, 1879

8. AGE: Years	Months	Days	If less than one day
65	10	26	hr. min.

9. Birthplace: Baltimore Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name: Thomas Cole
13. Birthplace: Washington, D. C.

MOTHER
14. Maiden Name: Mary Hill
15. Birthplace: Md.

16 (a) Informant: Balto. City Hospitals (Records)
(b) Address: 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/27/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A. A. Co. md.

18 (a) Funeral director Chas. H. Alexander
(b) Address 927 N. Mount St

19 (a) (Registrar) (b) Huntington Williams M.D. (Registrar)

NOV 26 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 20, 1945, at 6:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 12, 1945 to Nov. 20 1945 and that I last saw him alive on Nov. 20, 1945.

Immediate cause of death: Coronary Thrombosis — Duration:

Due to: arteriosclerotic Heart Disease

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation: none

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature T. P. Jerrigan M. D.

Address Baltimore City Hosp. Date signed 11-27-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634466 BALTIMORE CITY HEALTH DEPARTMENT 634466
CERTIFICATE OF DEATH 94a Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1916 N. McDonough St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1916 N. McDonough St
(If rural give location)
(e) Citizen of foreign country? X (Yes or No)
If yes, name country

3 (a) FULL NAME Grace E. Lynch

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 18th 1900

8. AGE: Years 45 | Months 1 | Days 4 | If less than one day hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John A. Williams
13. Birthplace England

MOTHER
14. Maiden Name Grace Simpson
15. Birthplace Md

16 (a) Informant Mr. Lynch
(b) Address 1916 McDonough St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 26th 1945 (month) (day) (year)

(c) Cemetery or crematory Parkwood
Location Taylor Ave

18 (a) Funeral director Leo. S. Cook
(b) Address 1701-03 N. Patterson Park Ave

19 (a) (b)
(Signature of registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 22nd 1945 at 1.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 23 1945 to Nov 22 1945, and that I last saw h[illegible] alive on Nov 22 1945.

Immediate cause of death Coronary thrombosis — Duration 1 hour

Due to

Due to

Other Conditions Bronchopneumonia — 3 weeks
Uremia
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

Signature W. H. Granger, M.D.
Address 1402 E. Lanvale Date signed 11-24-45

VS 150 Dr Granger 1402 E Lanvale St

G34467

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G34467

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3012 Belmont
(c) Hospital or institution: 16

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3012 Belmont Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LATIMER J. HAMM

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Gertrude M. Hamm
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 15, 1871

8. AGE: Years	Months	Days	If less than one day
74	9	10	hr. min.

9. Birthplace York Co., Pa.
(Town, county, and state)
10. Usual Occupation Retired Conductor
11. Industry or business Western Md. R. R.

FATHER
12. Name Jacob D. Hamm
13. Birthplace York Co., Pa.

MOTHER
14. Maiden Name Eliza Rohrbaugh
15. Birthplace York Co., Pa.

16 (a) Informant Mrs. Leona H. Mickey
(b) Address 3012 Belmont Ave.

17 (a) Burial (b) Date thereof 11/27/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Hampstead, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 26 1945 (b) Huntington Williams, M.D.
(Date received by Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/25/45 19 , at 9:54 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
(Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio Vascular Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Dawson M.D.
Medical Examiner.
Date signed 11/25/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34468

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 B

G34468 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Mitchell & Laynes
(c) Hospital or institution:
West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2615 Lauretta Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: HAZEL V. LEIDIGH

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife: Thomas J. Leidigh
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 7, 1916

8. AGE: Years	Months	Days	If less than one day
28	11	18	hr. min.

9. Birthplace Frederick, Md.
(Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business Food Fair

FATHER
12. Name Gilbert B. Young
13. Birthplace Frederick, Md.

MOTHER
14. Maiden Name Laura E. Bailey
15. Birthplace Frederick, Md.

16 (a) Informant Mr. William F. Wirth
(b) Address 2615 Lauretta Ave. 23

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/29/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 26 1945 (Date received by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/25 1945, at 3:40 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 11/25 1945 to 11/25 1945 and that I last saw her alive on 11/20 1945.

Immediate cause of death (Uremia — Pernicious anemia)	Duration
Due to Chronic Glomerulonephritis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hunterington Williams M. D.
Address West Baltimore General Hosp. Date signed 11-26-45

X

165116 G34469

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G34469 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1819 E-30th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Evelyn Efford

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Thomas J. Efford
6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) 3-24-01

8. AGE: Years	Months	Days	If less than one day
44	8	1	....hr. ....min.

9. Birthplace Md
(Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Joseph Rodert
13. Birthplace Md

MOTHER
14. Maiden Name Lillian Moore
15. Birthplace Md.

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Nov. 29-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore Co.
18 (a) Funeral director John A. Moan
(b) Address 3 W. E. Baltimore St.
19 (a) (b)
Registrar

NOV 27 1945
VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 25 - 1945, at 5 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov-17-1945 to 11-25-1945 and that I last saw h[illegible] alive on 11-25-1945.

Immediate cause of death	Duration
Respiratory failure	
Due to Cerebral hemorrhage	
Left hemiplegia	
Due to Hypertensive cardiovascular Disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature William J. Dieke
Address Johns Hopkins Hospital Date signed 11/25/45

X

034470

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

S-34470

Registered No. 942

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or Institution: West Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2017 Bryant Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SAM HECKER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years 53 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore Md (City, county and state)

10. Usual Occupation Optometrist

11. Industry or business

FATHER 12. Name Louis Hecker

13. Birthplace Austria

MOTHER 14. Maiden Name Dora Hendler

15. Birthplace Austria

16 (a) Informant David Hecker

(b) Address 2017 Bryant ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-26-45 (month) (day) (year)

(c) Cemetery or crematory Hebrew Friendship

Location Balto & Conklin

18 (a) Funeral director Jack Levin Inc

(b) Address 1439 E. Balto St.

19 (a) NOV 26 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/23/45 19..., at M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature John R. Davis M.D. Medical Examiner.

Date signed 11/26/45

PLEASE WRITE LEGIBLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

D34471

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

9-34471 300 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2803 Dennison St
(c) Hospital or institution:
15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2803 Dennison St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: LOUIS FINE

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: MALE

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: ADA

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years 71 | Months | Days | If less than one day hr. min.

9. Birthplace: RUSSIA (Town, county, and state)

10. Usual Occupation: NONE

11. Industry or business

FATHER
12. Name: ISRAEL
13. Birthplace: RUSSIA

MOTHER
14. Maiden Name: MINNIA
15. Birthplace: RUSSIA

16 (a) Informant: WIFE
(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 11-26-45 (month) (day) (year)
(c) Cemetery or crematory BALTO. HEBREW
Location BELAIR RD

18 (a) Funeral director JACK LEWIS INC
(b) Address 1437 E. BALTO. St.

NOV 26 1945 Huntington Williams M.D.
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 25 1945, at 5:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1943 to Nov 25 1945, and that I last saw h[illegible] alive on Nov 24 1945.

Immediate cause of death Uremia — Duration about one year

Due to Nephrosclerosis & chronic pyelonephritis

Due to Hypertensive cardiovascular renal disease; urinary tract infection

Other Conditions Tabes dorsalis arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Richard O Kahn M.D.

Address Marlborough Apts Date signed 11/25/45

1701 Eutaw Place 131a

VS 150

G34472

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G34472 Registered No. 1310

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33 Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) Norman

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1807 Bloomingdale Road
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country China

3 (a) FULL NAME Bow Yep (Bow Yep)

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex: Male
5. Color or race: Chinese
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Mrs Toy Shee Yep
6 (c) If alive, give age 35 years
7. Birth date of deceased (mo., day, yr.) February 3 1893
8. AGE: Years 52 | Months 9 | Days 15 | If less than one day ____ hr. ____ min.
9. Birthplace China (Town, county, and state)
10. Usual Occupation Laundryman
11. Industry or business Self-Employed

FATHER
12. Name Not Known
13. Birthplace China

MOTHER
14. Maiden Name Not Known
15. Birthplace China

16 (a) Informant James Yep (son)
(b) Address 1807 Bloomingdale Rd
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 26 45 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Hardlawn
18 (a) Funeral director Sturwick Mort Co.
(b) Address 108 W Monroe
19 (a) ____ (Date rec'd by registrar) (b) ____ Registrar

VS NOV 26 1945 Huntington Hillsdale, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH November 23 1945, at 5 45 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 14 1945 to Nov 23 1945; and that I last saw him alive on Nov 23 1945

	Duration
Immediate cause of death Hypertensive cardiovascular disease	
with nephrosclerosis and uremia	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. D. Garrard III M. D.
Address Union Memorial Hospital Date signed 11-28-45

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34473 ✓ G34473

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1135 Valley Street
(c) Hospital or institution: Home 10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1135 Valley Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Catherine Christine Bohli

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: George J. Bohli
6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) June-9-1886

8. AGE: Years 59 | Months 5 | Days 14 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name Edmond Storck
13. Birthplace Germany

MOTHER
14. Maiden Name ? ? Dreisel
15. Birthplace Not Known

16 (a) Informant Mrs. George J. Bohli (Husband)
(b) Address 1135 Valley Stret, City.

17 (a) Burial (b) Date thereof Nov 27/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Stewart & Mowen Co
(b) Address 108 W. North Ave, City.

19 (a) NOV 26 1945 (Date received by Registrar) Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 23 1945 at 8 00 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1940 to Nov 23 1945 and that I last saw her alive on Nov. 23 1945.

Immediate cause of death: Cerebral Hemorrhage — Duration 13 da

Due to Essential hypertension — 10 years

Due to hypertensive Cardiovascular Disease

Other Conditions Branchopneumonia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. H. Hamer M.D.

Address 1402 E Lamard St Date signed Nov 26 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34474

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

G34474 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1030 S. Eutaw Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Robert Melvin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Annie Melvin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 1883

8. AGE: Years 62 | Months | Days | If less than one day hr. min.

9. Birthplace: Fairmont Maryland (City, county, and state)

10. Usual Occupation: Laborer

11. Industry or business

FATHER 12. Name: George Melvin

13. Birthplace: Md.

MOTHER 14. Maiden Name: Catherine

15. Birthplace

16 (a) Informant: Annie Melvin

(b) Address: 1030 S. Eutaw St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-29-45 (month) (day) (year)

(c) Cemetery or crematory: Mt. Calvary

Location

18 (a) Funeral director: Elroy O. Wilson

(b) Address: 1000 Brookley Ave

19 (a) (Date received by registrar) (b) [signature] Registrar

NOV 26 1945

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 24 1945, at 5:35 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Gunshot wound of Abdomen

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 11-24-45 5:15 P.M.

(b) Where did injury occur? 1030 S. Eutaw St.

(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No

(d) Means of injury Shooting

23. Signature Robert L. Foster M.D. Medical Examiner.

Date signed Nov. 25 1945

634475

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 181

634475 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins 6

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6 North Bond (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES ANDERSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 19, 1944

8. AGE: Years	Months	Days	If less than one day
1	6 10	4	hr. min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name Charles Anderson
13. Birthplace N. C.

MOTHER
14. Maiden Name Pauline German
15. Birthplace N. C

16 (a) Informant Pauline Anderson
(b) Address 6 N. Bond St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/27/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brentley ave

19 (a) NOV 26 1945 (Date rec'd by registrar) (b) Livingston Rittler, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/23/45 19 , at 8:15 p M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Shock

Due to 3rd° Burns, 40% body

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11/23/45 at 7:30 a.m. M.
(b) Where did injury occur? 6 North Bond
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work?
(d) Means of injury Oil Stove Exploded

23. Signature John R. Burke Medical Examiner. M.D.
Date signed 11/24/45

VS 151

correct age is especially important. Physicians: please write the c... Every item of information should be carefully supplied. The ... the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34476

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13D

Registered No. G34476

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 120 S. Bond St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 120 S. Bond Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Arthur (otho) Counts

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Pauline Counts

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1913

8. AGE: Years 32 | Months | Days | If less than one day hr. min.

9. Birthplace S.C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name George Counts
13. Birthplace S.C.

MOTHER
14. Maiden Name Allice Counts
15. Birthplace S.C.

16 (a) Informant Pauline Counts
(b) Address 1203 Bonds

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 27 1945 (month) (day) (year)
(c) Cemetery or crematory Mt Calvery
Location Bowie Md

18 (a) Funeral director Bluy & Wilson
(b) Address 1000 Pratt St

19 (a) NOV 26 1945 (Date rec'd by registrar) (b) Huntington Wilkerson, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 23 1945, at 6:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive Cardiovascular Disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Medeiros M.D. Medical Examiner.
Date signed November 23, 1945.

(over)

VS 151

AB-97307 G34477

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G. Registered No. 38

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7days
(e) Length of stay in Baltimore (yrs., mos., or days) 16yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 140 Avon Beach Road-Turners (If rural give location) Station
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: William Thomas Lawrence

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced. Separated

6 (b) Name of husband or wife: Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 28- 1906

8. AGE: Years 38 | Months 11 | Days 24 | If less than one day ... hr. ... min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Baltimore City Hospitals (Record)
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-26-45 (Month) (day) (year)
(c) Cemetery or crematory Mt Calvery
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Bryant Lee Ave

19 (a) (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 28- 1945, at 8.25A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-15- 1945 to 11-22- 1945, and that I last saw h. in alive on 11-28- 1945

	Duration
Immediate cause of death: Tuberculoma Meningitis	2
Due to:	
Due to:	
Other Conditions: Pulmonary Tuberculosis (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy: Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert D. Copeland Jr

Address Balt. City Hosp. Date signed 11/23/45 M. D.

NOV

X

AB-97671 (33478)

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1312

Registered No. (33478)

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 22days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 23 N. Castle St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eva Victoria Chew

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Single ?

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 16- 1906

8. AGE: Years	Months	Days	If less than one day
38	11	8	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Howard Chew (D)
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Williams (D)
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 11-27-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvery
Location Elroy O. Wilson
18 (a) Funeral director
(b) Address 1000 Bl Stanley Ave
19 (a) (b)
(Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 24- 1945, at 11.30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-2- 1945, to 11-24 1945, and that I last saw h. alive on 11-24- 1945.

Immediate cause of death Cardiac failure — Duration
Due to Hypertensive cardiovascular disease
Due to
Other Conditions arteriolar nephrosclerosis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Marguerite Davis M. D.
Address 4940 Eastern ave. Date signed 11/25/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

930

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34479

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

830

Registered No. G34479

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 921 W. Franklin St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 921 W. Franklin St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Musetta Diggs.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widow

6 (b) Name of husband or wife James Diggs
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years	Months	Days	If less than one day
69			hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Pratt
13. Birthplace Md.

MOTHER
14. Maiden Name Ellen Jones
15. Birthplace Md.

16 (a) Informant Mrs. Ida Ijams
(b) Address 702 Mosher St.

17 (a) Burial (b) Date thereof 11-26-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) 26 1945 (b) Wm. Lexington Williams M.D.
(Signature of Registrar)

VS 150

MEDICAL CERTIFICATION

A

20. DATE OF DEATH November 22, 1945 at 10:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 23 1945 to Nov 22 1945. and that I last saw her alive on Nov 22 1945.

Immediate cause of death	Duration
Cerebral hemorrhage	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Julius S. White M. D.
Address 1543 Penna Ave Date signed 11-27-45

X

G34480

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V93D

Registered No. G34480

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 810 Hanover Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Caldwell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years 59 | Months | Days | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mary Caldwell (D)
(b) Address 810 Hanover St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-26-45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Ct
Location A. A. Co., Md.

18 (a) Funeral director Isaiah L. Brown & Son
(b) Address 1624 Montgomery St

19 (a) NOV 26 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 21, 1945 at 10 M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skotarelic M.D. Medical Examiner.
Date signed 11-21-45

Dr. Harbold
4706 Harford Rd.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G34481
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2808 List Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2808 List Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Joseph Hayes, Sr.

3 (b) If veteran, name war
3 (c) Social Security Account No. 212-09-7930

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widowed

6 (b) Name of husband or wife Mary Hayes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 9, 1860?

8. AGE: Years	Months	Days	If less than one day
85?	11	15	hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mr. Charles J. Hayes, Jr.
(b) Address 2808 List Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/27/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road -14-

19 (a) (b)

NOV 26 1945 Huntington Williamsport Md.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH November 24 1945, at 11 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 11 1944 to Nov. 24 1945, and that I last saw him alive on Nov. 24 1945.

Immediate cause of death: Acute myocarditis — Duration: 3 days
Due to: acute cardiac collapse
Due to: Glomerulonephritis Cystitis
Due to: Arteriosclerosis myocarditis
Other Conditions: Anuria? Prostatitis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. V. Harbold M. D.
Address 4706 Harford Road Date signed 11/26/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34182 — BALTIMORE CITY HEALTH DEPARTMENT — G34182 Registered No.

CERTIFICATE OF DEATH 46D

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1706 N. Calhoun St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1706 N. Calhoun St (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel L. Martin

3 (b) If veteran, name war — 3 (c) Social Security Account No. —

4. Sex M | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. M.

6 (b) Name of husband or wife Helen G. Martin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 24 1873

8. AGE: Years 71 | Months 72 | Days 11 | 29 | If less than one day hr. min.

9. Birthplace Charleston S.C. (Town, county, and state)

10. Usual Occupation Minister of Gospel

11. Industry or business

FATHER — 12. Name Richard T. Martin
13. Birthplace S. C.

MOTHER — 14. Maiden Name Phyllis Simmons
15. Birthplace S. C.

16 (a) Informant Helen G. Martin
(b) Address 1706 N. Calhoun St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-27-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Balto. Co.

18 (a) Funeral director Samuel W. Chase & Son
(b) Address 638 N. Gilmor St.

19 (a) NOV 26 1945 (Date received by registrar) Registrar
Huntington Hollins, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-23- 1945; at 7.20 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-14- 1945, to 11-23- 1945 and that I last saw him alive on 11-23- 1945

Immediate cause of death	Duration
Carcinoma Rectum	6 Mos.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George C. Page M. D.
Address 816 N. Mount St (17) Date signed 11-26-45

G34483 BALTIMORE CITY HEALTH DEPARTMENT G34483

CERTIFICATE OF DEATH 93D

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH: DOA
(a) Baltimore City, Maryland
(b) Street address 2220 Prestman St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2220 Prestman St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Silberberg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	married

6 (b) Name of husband or wife Blanche

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1863

8. AGE: Years	Months	Days	If less than one day
82			hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Morton
13. Birthplace Russia

MOTHER
14. Maiden Name
15. Birthplace Russia

16 (a) Informant Wife
(b) Address

17 (a) Burial (b) Date thereof 11-26-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Pk. Rd & Hamilton Ave

18 (a) Funeral director Jack Levy Inc
(b) Address 1439 E Balto St

19 (a) (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 151 NOV 26 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/25 1945; at 5:10 P.M.

21. I certify that I took charge of the remains described above, held an Inspection - Inquest thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C-V disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature P. F. Zubrinski M.D.
Medical Examiner.
Date signed 11/26/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34484

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G34484
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Balto. Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 19 N. Eden St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) Rose Wolf
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years 65 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Home wife

11. Industry or business

FATHER
12. Name
13. Birthplace Russia

MOTHER
14. Maiden Name
15. Birthplace Russia

16 (a) Informant Mrs. Herman Wolf
(b) Address 2614 Loyola Northway

17 (a) (Burial, cremation, or removal) (b) Date thereof Nov. 26, 1945 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location

18 (a) Funeral director Jack Lewis Inc.
(b) Address 1439 E. Baltimore St

19 (a) (Date rec'd by registrar) (b) Huntington-Williams Mort. Sinai Hospital

VS 190 NOV 26 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 25, 1945, at 12:55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 24 1945 to Nov 25 1945, and that I last saw her alive on Nov 25 1945.

Immediate cause of death	Duration
Cerebral vascular hemorrhage	
Due to Arteriosclerotic hypertensive heart disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Irene H. Kleinschmidt M. D.
Date signed Nov 26

G34485

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G34485 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 814 Woodyear Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Robinson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Mary Robinson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 14, 1874

8. AGE: Years 71 | Months 6 | Days 10 | If less than one day hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Ben Robinson
13. Birthplace Va

MOTHER
14. Maiden Name Sarah Madison
15. Birthplace Va

16 (a) Informant Marie Hall
(b) Address 814 N. Woodyear St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-27-45 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn
Location Md

18 (a) Funeral director George R. Nelson
(b) Address 1303 Chestnut St

19. (a) (Date received by registrar) (b) Huntington Williams, M.D.

NOV 26 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH November 24, 1945, at 12 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Foster M.D.
Medical Examiner.
Date signed Nov. 25 1945

G34486

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G34486 Registered No. 194a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1515 Riggs Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Garrett

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	M

6 (b) Name of husband or wife John
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 4, 1899

8. AGE: Years	Months	Days	If less than one day
46	8	19	hr. min.

9. Birthplace Calvert Co Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Wesley Gross
13. Birthplace Md

MOTHER
14. Maiden Name
15. Birthplace Md

16 (a) Informant John Garrett
(b) Address 1515 Riggs Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/28/45 (month) (day) (year)
(c) Cemetery or crematory Arbutus
Location Md.

18 (a) Funeral director Geo. S. Kelson
(b) Address 1303 Pressman St

19 (a) (Signature of registrar) (b) Huntington Williams, M.D. Registrar

NOV 26, 1945
VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 23 1945, at 10:38 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral edema, marked
Due to Coronary sclerosis
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skotarchic M.D. Medical Examiner.
Date signed Nov 24, 1945.

G34487

G34487

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 132

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3710 Sequoia Ave.
(c) Hospital or institution: Shriner,s Nursing Home 15 11
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3710 Sequoia Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Luella F. Brown

3 (b) If veteran, name war ------

3 (c) Social Security Account No. ----------

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Elliott J. Brown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10, 1871

8. AGE: Years	Months	Days	If less than one day
74	5	14	hr. min.

9. Birthplace Mifflin County Pa. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name David R. Hanawalt
13. Birthplace Mifflin County Pa.

MOTHER
14. Maiden Name Mary Fields
15. Birthplace Pennsylvania

16 (a) Informant J.C. Hanawalt
(b) Address 3710 Sequoia Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 27, 45 (month) (day) (year)
(c) Cemetery or crematory Mapleton
Location Pa.

18 (a) Funeral director Ellsworth Ormsby
(b) Address 3911 Liberty Heights Ave.

NOV 26 1945 (Date rec'd by registrar) Huntington for Nathaniel, M.D. Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 24 1945, at 6 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 20 1945 to Nov 23 1945, and that I last saw her alive on Nov 23 1945.

Immediate cause of death	Duration
Myocardial Insufficiency	6 M O
Due to Arteriosclerosis	2 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Archey Davies M. D.
Address 800-U 33rd Date signed 11-25-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34488

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G34488

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 644 Dover St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 644 Dover St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katie Bell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Charles Bell.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15, 1899.

8. AGE: Years 46 | Months 6 | Days 8 | If less than one day hr. min.

9. Birthplace Roanoke, Virginia
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Hannie Walker
15. Birthplace Roanoke, Va.

16 (a) Informant Anglee Turner
(b) Address 718 W. Fairmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 27 '45 (month) (day) (year)

(c) Cemetery or crematory Baltimore National
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) NOV 26 1945 (b) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 23 1945, at 11 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1945 to Nov 23 1945 and that I last saw h. alive on Nov 22 1945

Immediate cause of death	Duration
Acute Cardiac Dilatation	One day
Due to Hypertensive Cardio Vascular disease	3
Due to	
Other Conditions Diabetes	?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Henry Glassman M. D.

Address 213 W. Fayette St. Date signed Nov 26/45

937

G34489

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G34489 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 West Cold Spring Lane
(c) Hospital or institution: Cold Spring Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: Baltimore
(a) State Md. (b) County Chesaco Park
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 401 Potomac Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Agnes B. Ruley

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widow

6 (b) Name of husband or wife Late James Ruley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 1, 1862

8. AGE: Years	Months	Days	If less than one day
83	10	22	hr. min.

9. Birthplace Baltimcre
(Town, county, and state)
10. Usual Occupation housewife at home
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name
15. Birthplace "

16 (a) Informant Wm. J. Ruley - son
(b) Address 1327 Spring Ave, Zone 6

17 (a) Burial (b) Date thereof 11/27/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Edmonson Avenue

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 East Madison Street

19 (a) (b) NOV 26 1945
(Date rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 23 1945, at 6 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 10 1945, to Nov. 23 1945, and that I last saw h.sw. alive on Nov. 20 1945.

Immediate cause of death	Duration
chronic myocarditis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

Signature M. N. Patterson M. D.
Address 2124 Pennsylvania Ave. Date signed 11/24/45

X

G34490

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1927

G34490 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2420 Ashland Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-V
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2420 Ashland Avenue
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME ROSE PICEK

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or ~~wife~~ James Picek
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/9/04

8. AGE: Years 41 yrs. | Months 9 | Days 16 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Anton Klimes
13. Birthplace Czechoslovakia

MOTHER
14. Maiden Name Rose Kristof
15. Birthplace Czechovakia

16 (a) Informant Mr. James Picek
(b) Address 2420 Ashland Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/28/45 (month) (day) (year)
(c) Cemetery or crematory Oak Hill
Location Phila Rd. Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 Allison Street

19 (a) (Date rec'd by registrar) NOV 29 1945 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 25 1945 at 2:45 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 24 1945 to Nov. 25 1945 and that I last saw h[illegible] alive on Nov. 25 1945.

Immediate cause of death	Duration
Coronary Thrombosis of Heart	4 hrs
Due to Chr. Valvular Heart Disease	?
Due to Acute Rheumatic Fever	?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury

23. Signature Lawrence J. Tooka M.D.
Address 845 N. Collington Ave. Date signed 11/28/45 M D

Huntington Ave

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34491

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1170

G34491 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4519 Wilmslow Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elsie Lydia Rosier

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Russell H. Rosier

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 16, 1912

8. AGE: Years 33 | Months 2 | Days 9 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Secretary

11. Industry or business Brown 5+10 cent store

FATHER
12. Name Millard O Leese
13. Birthplace Md.

MOTHER
14. Maiden Name Lydia A Bommer
15. Birthplace Md.

16 (a) Informant Lydia A. Leese
(b) Address 4519 Wilmslow Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn Md.

18 (a) Funeral director Chenoweth & Donovan
(b) Address 2615-17 Lakewood Ave.

19 (a) (Date received by Registrar) (b)

NOV 26 1945

Registrar for Williamsport, Md.

VS 101

MEDICAL CERTIFICATION

20. DATE OF DEATH November 25, 1945, at 11 17 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of neck
Complete severing of
DUE TO spinal cord

Other Conditions Fracture of rt. lower leg

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-25-45 at 11 P. M. 27/8
(b) Where did injury occur In front of 5859 York Rd.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian struck by auto.

23. Signature Benedict Skotarek M.D.
Medical Examiner.

Date signed 11-26-45

G34492

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 Σ

G34492 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1312 Appleby Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1312 Appleby Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nelson F. Caltrider.

3 (b) If veteran, name war: 1st W.W.
3 (c) Social Security Account No. 218-07-5108

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married.

6 (b) Name of husband or wife: Christine P. Caltrider
6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) Dec 28, 1894

8. AGE: Years	Months	Days	If less than one day
50	11	25	hr. min.

9. Birthplace maryland. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Plasterer.

FATHER
12. Name John Caltrider.
13. Birthplace maryland.

MOTHER
14. Maiden Name Florence Foard.
15. Birthplace maryland.

16 (a) Informant Christine P. Caltrider
(b) Address 1312 Appleby Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 26/45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn.
Location

18 (a) Funeral director Ahearn & Sonnemann
(b) Address 3615-17 Chestnut Ave.

19 (a) (Date rec'd by registrar) (b)

NOV 26 1945

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 22, 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 31 1945 to Nov 22 1945. and that I last saw him alive on Nov. 20 1945.

Immediate cause of death	Duration
Coronary Thrombosis	½ hr.
Due to Coronary artery disease	4 yrs
Due to Myocarditis	4 yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. E. Nichols, M. D.
Address Pikesville Md. Date signed 11-24-45

X

G34493

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 109

G34493 Registered No.

WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address —
(c) Hospital or institution: West Balt Gen Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 9 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Baltimore (Glen Burnie)
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5 a l A Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Regina Dorothy Scanlon

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: W

6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/14/45

8. AGE: Years | Months | Days: 9 | If less than one day hr. min.

9. Birthplace West Balt. Gen Hosp
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Edward Thomas Scanlon
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Mary Cath. Bohegan
15. Birthplace Baltimore Md

16 (a) Informant Hosp. Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-26-1945 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore Md.

18 (a) Funeral director Flynn & Fleming
(b) Address 1422 Light St.

19 (a) (Date rec'd by local reg.) (b) Kingston Williams, M.D.

NOV 26 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/23 1945; at 9:15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/15 1945 to 11/23 1945 and that I last saw her alive on 11/23 1945.

Immediate cause of death Unknown.

	Duration
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None grossly

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. Silverfeld
Address West Balt Gen Hosp Date signed 11/26/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634494

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. 634494

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution:
Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) ~~City or town~~ No 1006 S. Ellwood Ave
(If outside city or town limits, write RURAL and give town)
(d) ~~Street No.~~ Town Baltimore
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rev. Thomas Davis (Thomas Settles Davis)

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Roberta E. Davis
6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) Oct. 27, 1874

8. AGE: Years	Months	Days	If less than one day
71	1	24	hr. min.

9. Birthplace North Carolina
(Town, county, and state)
10. Usual Occupation Clergyman
11. Industry or business

FATHER
12. Name Jennings Davis
13. Birthplace North Carolina

MOTHER
14. Maiden Name Mary E. Fischer
15. Birthplace North Carolina

16 (a) Informant Mrs. Roberta E. Davis
(b) Address 1006 S. Ellwood Avenue

17 (a) Burial (b) Date thereof 11-27-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) (b)
NOV 26 1945
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/24 1945 at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/24 1945 to 11/24 1945 and that I last saw him alive on 11/24 1945

Immediate cause of death Coronary Thrombosis — Duration 2 days

Due to Arteriosclerotic C.V. Disease

Due to

Other Conditions Pat. treated at home for some time for 1 day before admission

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Martin E. Stroebel M. D.
Address Md. Gen'l Hospital Date signed 11/24/45

X

G34495

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 33B

Registered No. G34495

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Herring Run & Harford Rd.
(c) Hospital or institution: Sydenham Hospital 25
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 days
(e) Length of stay in Baltimore (yrs., mos., or days) 9 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3640 Marsden Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Freda Shea

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex Female 5. Color or race White 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 17, 1945

8. AGE: Years | Months 10 9 | Days 9 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business None

FATHER
12. Name William Shea
13. Birthplace Maryland

MOTHER
14. Maiden Name Freda Loughlin
15. Birthplace Maryland

16 (a) Informant Mrs. Freda Loughlin Shea
(b) Address 3640 Marsden Court

17 (a) Burial (b) Date thereof Nov 28 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cemetery
Location Pulaski Highway & R.R.

18 (a) Funeral director Elizabeth Shea Funeral Home
(b) Address 115 S. Paca St.

19 (d) NOV 26 1945 Huntington Williams, Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 26 1945 at 3 35 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-30 1945 to 11-26 1945 and that I last saw her alive on 11-26 1945.

Immediate cause of death	Duration
Internal Hydrocephalus	
Due to Influenza Meningitis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Mekinzie Sprague M.D.
Address Sydenham Hosp. Date signed 11-26-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The cause of death clearly and legibly. Physicians: please write the causes of death clearly and legibly.

G34496

CMK-27446

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 82

G34496 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 41 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 672 W. Fayette Street
(If rural give location)
(e) Citizen of foreign country? [redacted] (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Bukauskas

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Marcella
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 21-1890

8. AGE: Years	Months	Days	If less than one day
55	5	4	hr. min.

9. Birthplace Lithuania
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 29-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd

18 (a) Funeral director Joseph Kasmskas Jr
(b) Address 640 S Whsh. Blvd

NOV 26 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 25 1945 at 9 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 23 1945 to Nov. 25 1945 and that I last saw h. im alive on Nov. 25 1945.

Immediate cause of death Uraemia

Due to Toxemia from overwhelming infection.

Due to

Other Conditions Syringomyelia
Def. Rt. upper arm
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Swollen kidneys, arteriosclerosis

of autopsy:

Duration
?
?

PHYSICIAN
I[redacted] the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ?
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Margaret M. Davis M. D.
Address 4940 Eastern ave. Date signed Nov 25/45

X

634197

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. 634196

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 602 S. Bond St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hoost Sozoulakis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Catherine
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-15-95

8. AGE: Years	Months	Days	If less than one day
49	3	10	hr. min.

9. Birthplace Turkey (Town, county, and state)
10. Usual Occupation Chauffeur
11. Industry or business

FATHER
12. Name Chris Sozoulakis
13. Birthplace Turkey

MOTHER
14. Maiden Name Catherine ?
15. Birthplace Turkey

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 28 45 (month) (day) (year)
(c) Cemetery or crematory Druid Cemetery
Location Wilson Mall Rd.

18 (a) Funeral director Jenkins Funeral Home Inc
(b) Address 442 E North Ave.

19 (Signature and address of local registrar) NOV 26 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 25 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 22 1945 to Nov 25 1945, and that I last saw he alive on Nov 25 1945

Immediate cause of death	Duration
Intussusception - Malignant carcinoma of Stomach.	
Due to Anemia, biliary obstruction	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation April 11, 1945
Major findings of operation Carcinoma of Stomach
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Johnson Hellman M.D.
Address Johns Hopkins Hospital Date signed Nov 26 1945

VS 150

G34498 B.C. #38366

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 14

G34498 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 years 8 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 32 E. Hamburg St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Reese b Parks, Jr.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 27, 1941

8. AGE: Years	Months	Days	If less than one day
4		25	hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Reese b Parks Sr.
13. Birthplace Lafayette Co Miss

MOTHER
14. Maiden Name Mattie Parks
15. Birthplace Colored b.

16 (a) Informant Reese b Parks
(b) Address 32 E. Hamburg St

17 (a) Burial (b) Date thereof Nov 28, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cedar Hill b
Location Ft. Avenue b.

18 (a) Funeral director E. Howard Evans
(b) Address 1 [illegible] Baltimore St

(a) (b) Huntington Williams M.D.
(Signature of local registrar) Registrar

NOV 26 1945

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH November 25 1945, at 6:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 17 1945, to Nov. 25 1945, and that I last saw him alive on Nov. 25 1945.

Immediate cause of death	Duration
Meningitis, possible Tuberculous.	
Due to	
Due to	
Other Conditions Pulmonary infiltration, right hilum (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Reece R. Boone Jr. M.D.
Address Univ. Hospital Date signed 11/25/45

634499

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 634499

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 30 E Hill Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JANNIE CUCINA

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 5 1880

8. AGE: Years 64 | Months 11 | Days 12 | If less than one day hr. min.

9. Birthplace Italy
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business home

FATHER
12. Name Dominic La Rosa
13. Birthplace Italy

MOTHER
14. Maiden Name Josephine ?
15. Birthplace

16 (a) Informant Catherine Cucina (Daughter)
(b) Address 30 E. Hill St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nove. 27 1945 (month) (day) (year)
(c) Cemetery or crematory ~~XXXXXXX~~ New Cathedral
Location Old Frederick Rd.

18 (a) Funeral director Frank Della Rose
(b) Address 52 N. Morley St.

NOV 26 1945 (Date rec'd by Registrar) (By) Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/23/45 19..., at 11:22 P.M.

21. I certify that I took charge of the remains described above, held an Inspection Inquest thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardio Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Wurst M.D.
Medical Examiner
Date signed

634500

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170C

Registered No. 634500

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2132 N. Wolfe Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Currari

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Augustina Currari

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/5/1899

8. AGE: Years 46 | Months 6 | Days 20 | If less than one day hr. min.

9. Birthplace Cefalu, Italy (Town, county, and state)

10. Usual Occupation Barber

11. Industry or business

FATHER 12. Name B. Andrea Currari

13. Birthplace Italy

MOTHER 14. Maiden Name Dachina Cimino

15. Birthplace Italy

16 (a) Informant Augustina Currari

(b) Address 2132 N. Wolfe St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/29/45 (month) (day) (year)

(c) Cemetery or crematory: Italy Redeemer

Location Belgian Rd Balto Md

18 (a) Funeral director: Frank Della Rose

(b) Address 524 N. Marley st.

19 NOV 26 1945 (Date rec'd by registrar) Christopher Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 25 1945 at 6 45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Jan 1 death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Ruptured spleen
Ruptured Left kidney
Contusion of brain

Other Conditions Fracture of left arm and leg
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 11-25-45 at 6 15 P.M. 8/5

(b) Where did injury occur? Harford Rd. & Darley Ave.

(c) Did injury occur at home, on farm, industrial place or public place? Public While at work? no

(d) Means of injury Pedestrian struck by auto

23. Signature Benedict Skaturske Medical Examiner. M.D.

Date signed 11-26-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful applied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634501

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93E

Registered No. 634501

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1432 Reynolds St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 M
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1432 Reynolds St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Wisniewski

3 (b) If veteran, name war

3 (c) Social Security Account No. 214 22 6140

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Frances Wisniewski
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 15. 1885

8. AGE: Years	Months	Days	If less than one day
60	7	10	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Stevedore
11. Industry or business

FATHER
12. Name Jacob Wisniewski
13. Birthplace Poland

MOTHER
14. Maiden Name Unk.
15. Birthplace Poland

16 (a) Informant Frances Wisniewski
(b) Address 1432 Reynolds St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 28/45 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Fred W. Ozarowski
(b) Address 1930 Eastern Ave.

19 (a) (Date received by Registrar) NOV 26 1945 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 25/45 19 , at 3A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 16 1945 to Nov 25 1945.
and that I last saw h alive on Nov. 24 1945

Immediate cause of death Cardiac Arthma
Terminal Bronchial Pneumonia

	Duration
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Antonio Stanislaus M. D.
Address 1432 Eastern Ave Date signed

Huntington Williams, Md

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634502 AB-97219

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 634502

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 413 Cummings St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Henry Marshall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 13- 1881

8. AGE: Years	Months	Days	If less than one day
64	0	10	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Warehouse man
11. Industry or business

FATHER
12. Name Joseph Henry Marshall
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Kate Butcher
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof Nov. 27, '45.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 NOV 26 1945 Huntington Williams, M.D.
Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 23- 1945, at 2.22A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-15- 1945, to 11-23 1945, and that I last saw h. in alive on 11-23- 1945

Immediate cause of death Coronary occlusion — Duration 7

Due to — Duration

Due to — Duration

Other Conditions Hypertensive Heart Disease — Duration 8
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy coronary occlusion, perforation of ulcer, stomach, H&P D

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Margaret Davis M. D.
Address 4940 Eastern Ave. Date signed 11/23/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34503
CWK-97478

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 939

G34503
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hour
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 608 N. Patterson Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Hinkle V. Mattews or Matthews

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 5, 1869

8. AGE: Years	Months	Days	If less than one day
75 ?	11	19 20	hr. min.

9. Birthplace ?
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof Nov 28/1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore, Md.

18 (a) Funeral director Williams Cooke, Inc
(b) Address 1217 Lt. and Lt. St.

19 (a) (b) Huntington Williams, M.D.
Registrar

NOV 26 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 25 1945, at 12:04 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 24 1945, to Nov. 25 1945, and that I last saw him alive on Nov. 25 1945.

Immediate cause of death	Duration
Cardiac failure	?
Due to, Arteriosclerotic heart disease.	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: arteriosclerotic H. disease pulmonary edema.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Margaret M. Davis
Address 4940 Eastern Ave. Date signed 11/25/45 M. D.

Subject to the approval of the Medical Examiner
Approved, Robert L. Gaston M.D. X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34504 HB#96874

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V186a

G34504 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 80 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2007 Annapolis Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Louise Martino

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 13- 1854

8. AGE: Years 91 | Months 0 | Days 11 | If less than one day ... hr. ... min.

9. Birthplace Kentucky
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Herig
13. Birthplace Germany

MOTHER
14. Maiden Name Gertrude Hunt
15. Birthplace France

16 (a) Informant Baltimore City Hospitals(Records)
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 26 1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md

18 (a) Funeral director William Cook Sons
(b) Address 1217 St. Paul St.

19 (a) (b) Huntington Williams, M.D.
(Date received by registrar) NOV 26 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH November 24, 1945, at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 24, 1945 to Nov. 24, 1945 and that I last saw her alive on Nov. 24, 1945.

Immediate cause of death Congestive heart failure — Duration

Due to Generalized arteriosclerosis and hypertension — Duration

Due to arteriosclerosis — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: ...

of autopsy: ...

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence October 9, 1940 M
(c) Where did injury occur? Balto. Md
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? at home While at work? no
(Specify type of place)
(e) Means of injury Fall to floor at home

23. Signature E. [illegible] M. D.
Address B. C. H. Date signed 11-27-45

PHYSICIAN
Underline the cause to which death should be charged statistically.

To be approved by Medical Examiner.
11/26/45 Robert Lee Graham M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34505

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183a

G34505 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway
(c) Hospital or institution Church Home & Hospital
(d) Length of stay in hospital or inst. (~~yrs., mos.~~, or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2817 Jefferson, S (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Deangler

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Josephine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 25 1887

8. AGE: Years 58 Months 6 Days 29 If less than one day ..... hr. ..... min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Charles Deangler
13. Birthplace

MOTHER
14. Maiden Name Margaret Drechsel
15. Birthplace Germany

16 (a) Informant Hosp. records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 28 45 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Gwynn Oak Rd

18 (a) Funeral director Mod. W.E. Degel
(b) Address 37 S. Carey St.

19 (a) Filed by registrar Washington Nelligan NOV 26 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-24-1945, at 8 p.m.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-22 1945 to 11-24 1945 and that I last saw h~~im~~ alive on 11-24 1945.

Immediate cause of death Cerebral Vascular accident — Duration 3d.

Due to Hypertension — 6 yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Frank M. Slaughter M. D.
Address Church Home & Hosp. Date signed 11-25-45

X

634506

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

634506
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore 6 (If outside city or town limits, write RURAL and give town)
(d) Street No. 3 Henry Avenue (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julius Volz

3 (b) If veteran, name war: no

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: 216-03-1775

6 (b) Name of husband or wife: Lena Volz

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 20th 1879

8. AGE: Years 66 | Months 3 | Days 5 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Bar Tender

11. Industry or business Hotel

FATHER
12. Name Michael Volz
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Mrs. Lena Volz
(b) Address 3 Henry Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 28 45 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto. Md.

18 (a) Funeral director Lansdale Funeral Ho.
(b) Address 7401 Belair Rd.

NOV 26 1945 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 25 1945 at M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Subarachnoid
Hemorrhage, Traumatic
Due to Compound Comminuted Fractures of Lower Legs

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-22-45 at 2 A. M. Cable Car,
(b) Where did injury occur? 35' south of Overlea Ave. on Rt. 1 (Belair Rd)
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian struck by auto.

23. Signature [illegible] M.D.
Medical Examiner.
Date signed Nov. 25 1945

G34507

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G34507 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ~~[illegible]~~ Redwood Green
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 46yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Towson Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 22 Normal Terrace
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) **FULL NAME** Margaret Conway Bryant

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Thomas Bryant

6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) June 12 1899

8. AGE: Years 46 | Months 5 | Days 12 | If less than one day ____ hr. ____ min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Edward Murphy
13. Birthplace Maryland

MOTHER
14. Maiden Name Julia Conway
15. Birthplace Maryland.

16 (a) Informant Husband
(b) Address Same as above

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/29/45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Johnnell Md

18 (a) Funeral director Pickup Funeral Home
(b) Address 1211 E Fort Ave

19 (a) ____ (b) ____ Registrar

NOV 28 1945

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH NOV 24 1945; at 2:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1945 to NOV 24 1945, and that I last saw her alive on Nov 24 1945.

	Duration
Immediate cause of death Cerebral Hemorrhage	
Due to Hypertensive CV Disease	
Due to	
Other Conditions Chronic Nephritis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. W. Boggs M.D.
Address 1211 E Fort Ave Date signed 11/24/45

X

G34508

BALTIMORE CITY HEALTH DEPARTMENT

HEP #97320

CERTIFICATE OF DEATH

G34508 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 57 Yrs. ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 708 Sterling St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Andrew Jefferson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Black

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? 1868

8. AGE: Years 57 ? | Months ? | Days ? | If less than one day ... hr. ... min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ? ? ?
13. Birthplace ?

MOTHER
14. Maiden Name ? ? ?
15. Birthplace ?

16 (a) Informant Balto. City Hospitals Records
(b) Address 4940 Eastern Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School NOV 26 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 NOV 26 1945 (Date received by registrar) Huntington Williams, M.D.

VS 150

3099

X

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 19, 1945, at 9:00a M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 15, 1945, to Nov. 19, 1945, and that I last saw h im alive on Nov. 19, 1945.

Immediate cause of death	Duration
Pneumonia	?
Due to Meningitis	?
Cardiac failure	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Margaret M. Dunn M. D.

Address 4940 Eastern Ave. Date signed 11-21-45

G34509

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

Registered No. G34509

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) d.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 422 Lawrence Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Knight

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1895

8. AGE: Years	Months	Days	If less than one day
50			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School NOV 26 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) NOV 26 1945 (Date rec'd by Registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 13th 1945, at 6:35 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet Wounds of chest, upper right arm.

Due to

Other Conditions Fracture right humerus

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-13-45 at 4 A. M.
(b) Where did injury occur? 422 Lawrence St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Shooting

23. Signature Benedict Shiturelis M.D. Medical Examiner.
Date signed 11-14-45

VS 151

3098

G34510

HEALTH DEPARTMENT—CITY OF BALTIMORE

G34510

CERTIFICATE OF DEATH ✓ 109a

1. PLACE OF DEATH Volunteers of Amer. Hospt. Registered No.....

CITY OF BALTIMORE: (No. 418 W. Lexington St. ✓ Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ...yrs. ...mos. 10 da. How long in U. S. If of foreign birth? ...yrs. ...mos. ...da.

If U. S. Veteran specify WAR.....

2. FULL NAME BERTIE LEE KELLAM ✓

(a) Residence: No. 751 W. BALTIMORE St., ...Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
F	W	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, year) NOV. 12 1945

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
		10	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.....

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.....

10. Date deceased last worked at this occupation (month and year).....

11. Total time (years) spent in this occupation.....

12. BIRTHPLACE (city or town).....
(State or country)

FATHER

13. NAME Ralph James Killam

14. BIRTHPLACE (city or town) Onancock, Va.
(State or country)

MOTHER

15. MAIDEN NAME Georgia Frances Arrington

16. BIRTHPLACE (city or town) Charleston W. Va.
(State or country)

17. INFORMANT Georgia Frances Killam
(Address) 751 W. Lexington St.

18. BURIAL, CREMATION, OR REMOVAL
Place..... Date..... 19..

19. UNDERTAKER University Medical School NOV 26 1945
(Address) Commissioner of Health

20. FILED NOV 26 1945 Huntington Williams, Registrar.

MEDICAL CERTIFICATE OF DEATH ✓

21. DATE OF DEATH (month, day, year) Nov. 22, 1945

22. I HEREBY CERTIFY, That I attended deceased from Nov. 12, 1945, to Nov. 22, 1945

I last saw her alive on Nov. 21, 1945. Death is said to have occurred on the date stated above, at 10.00 a.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Virus pneumonia	Nov 20th

Other contributory causes of importance:

Was an operation performed?..... Date of.....

For what disease or injury?.....

Name of operation.....

What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide?..... Date of injury....., 19..

Where did injury occur?.....
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.....

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?

If so, specify.....

(Signed) Kennard Yaffe M. D.

(Address) Volunteers of America Hosp.

11/22/45

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V0 3

3100 X

G34511

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161a

G34511 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 711 Pa Avenue
(c) Hospital or institution:
17
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Newborn

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 711 Pa Ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Delois O Pryor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/23/45

8. AGE: Years	Months	Days	If less than one day
0	0	1	hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joseph Pryor
13. Birthplace Charleston, SC.

MOTHER
14. Maiden Name Mary Shepard
15. Birthplace Virginia

16 (a) Informant Mary Pryor
(b) Address 711 Pa Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School NOV 26 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 NOV 26 1945 (Date rec'd by registrar) (Huntington Williams) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/24 1945, at 8:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/23 1945 to 11/24 1945 and that I last saw h[er] alive on 11/23 1945.

Immediate cause of death:	Duration
(a) Asphyxial Livida	
Due to Neonatorum	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Emerson R. Julian M. D.
Address 434 E. 33rd St Date signed 11/24/45

VS 150

3101

X

G34512

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G34512 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 11
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 929 N. Calvert St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gus G. Drews

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 285-09-9742

4. Sex: Male | 5. Color or race: White | 6 (a) Single, ~~married, widowed, or divorced~~: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec about 1880

8. AGE: Years: about 64 | Months: 11 | Days | If less than one day: hr. min.

9. Birthplace: Boston Mass
(Town, county, and state)

10. Usual Occupation: Cook

11. Industry or business: Lord Balto. Hotel

FATHER
12. Name: Unknown Drews
13. Birthplace: "

MOTHER
14. Maiden Name: "
15. Birthplace: "

16 (a) Informant: Mr. Agostino Passalacqua
(b) Address: 410 E. Chase St.

17 (a) Burial (Burial, ~~cremation or removal~~) (b) Date thereof 11/27/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~: Holy Redeemer
Location: Balto. Md.

18 (a) Funeral director: William Cook Inc
(b) Address: 1217 St. Paul St.

NOV 26 1945 (Date rec'd by registrar)

(b) Registrar: Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 24 1945; at 9:15 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Myocardial fibrosis

Due to Arteriosclerotic cardiovascular disease

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Fraley M.D.
Medical Examiner.
Date signed 11-24-45

G34513

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1108

G34513
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mount Hope Retreat
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs 5 mos
(e) Length of stay in Baltimore (yrs., mos., or days) 53 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 504 S. Bentalow St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Kunigunda Krevsingere
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Ludwig
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 26, 1873

8. AGE: Years 72 | Months 7 | Days 27 | If less than one day hr. min.

9. Birthplace Bavaria, Germany (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George Probst
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Sebald
15. Birthplace Germany

16 (a) Informant Mount Hope Retreat
(b) Address 6420 Reisterstown Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-28-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md

18 (a) Funeral director George H. Eyler
(b) Address Fulton & Laurens St

19 (a) (Date rec'd by registrar) (b) Registrar
NOV. 26 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 25 1945, at 6.55 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 16 1943, to Nov. 25 1945, and that I last saw him alive on Nov. 25 1945

Immediate cause of death: Left Lobar pneumonia — Duration: 5 days
Due to
Due to
Other Conditions: Phthisis with arteriosclerosis — 2 years
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Damian C. Flagiello M. D.
Address 2316 Madison Ave Date signed

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34514

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1161C

Registered No. G34514

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: MERCY HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 14 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 724 BELGIAN Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** BABY BOY FRANGIONE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/24/45

8. AGE: Years	Months	Days	If less than one day
			14 hr. min.

9. Birthplace MERCY HOSP., BALTO., Md. (Town, county, and state)
10. Usual Occupation NONE
11. Industry or business NONE

FATHER
12. Name ELMER HAWKINS FRANGIONE
13. Birthplace NEW YORK, N.Y.

MOTHER
14. Maiden Name ELSIE KITTELL
15. Birthplace NEW YORK, N.Y.

16 (a) Informant ELSIE KITTELL FRANGIONE
(b) Address 724 BELGIAN Ave, Balto.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/27/45 (month) (day) (year)
(c) Cemetery or crematory St. Peters
Location Balt.

18 (a) Funeral director George A. Farley
(b) Address Fulton & Fayette Sts.

19 (a) (Date rec'd by registrar) NOV 28 1945 (b) Huntington Williamsport Md.

VS 15

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 25, 1945 19 at 7:03 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/24 1945 to 11/25 1945 and that I last saw h.i.m alive on 11/25 19 45

Immediate cause of death: Hemorrhagic disease of newborn. — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation NONE

Major findings of operations:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John A. Hedrick M. D.
Address Mercy Hospital Date signed 11/25/45

634515

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 86

634515 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Balto. City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 M
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1137 E. Balto St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Blake

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1912

8. AGE: Years 33 | Months | Days | If less than one day hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Jacob
13. Birthplace Russia

MOTHER
14. Maiden Name Anna
15. Birthplace Russia

16 (a) Informant Hospt Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-27-45 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philad Rd & Hamilton Ave

18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E. Balto St

19 (a) (Date signed by undertaker) (b) Huntington Williams M.D. Registrar

NOV 27 1945

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/25 1945, at 6:15 P M

21. I certify that I took charge of the remains described above, held an Inspection + Inquest thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
(a) Lobar Pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature P. J. Sabinske M.D.
Medical Examiner.
Date signed 11/26/45

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634516

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

163H Registered No. 634516

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto. General Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2845 Old Spring Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Shapiro

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	married

6 (b) Name of husband or wife Jack

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1912

8. AGE: Years	Months	Days	If less than one day
33			hr. min.

9. Birthplace Warrington Va
(Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER
12. Name Israel Lavenstein
13. Birthplace Russia

MOTHER
14. Maiden Name Anna Cohen
15. Birthplace Russia

16 (a) Informant Husband
(b) Address

17 (a) Burial (b) Date thereof 11-27-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location Lemmon Hills Rd.

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Baltimore St.

19 (a) NOV 27 1945 (b)
(Date received by registrar) Registrar

VS 151

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/25 1945, at 9:00 P M

21. I certify that I took charge of the remains described above, held an Inspection - Inquiry thereon and from the evidence obtained
(Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to ... death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Asphyxia due To
Illuminating gas
Due to

Other Conditions Despondency
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11/25/45 at about 8:30 P M.
(b) Where did injury occur? 2845 Old Spring Lane
(c) Did injury occur at home, on farm, industrial place, in public place? at home While at work? No
(d) Means of injury Inhalation of gas fumes

23. Signature P. A. Schenck M.D.
Medical Examiner.
Date signed 11/26/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34517

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G34517
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1636 E. Baltimore St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1636 E. Baltimore Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Max Kaplan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Bertha

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years 60 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace: Russia
(Town, county, and state)

10. Usual Occupation: Retired

11. Industry or business

FATHER
12. Name: Joseph Kaplan
13. Birthplace: Russia

MOTHER
14. Maiden Name: Rachel
15. Birthplace: Russia

16 (a) Informant: Boris M. Harrison
(b) Address: 5028 N. Queensberry Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-27-45 (month) (day) (year)
(c) Cemetery or crematory: Herring Run
Location: Phil Rd & Bowleys Lane

18 (a) Funeral director: Jack Lewis Inc.
(b) Address: 1439 E. Balto St

19 (a) NOV 27 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 26 1945 at 12 50 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Hypertensive cardiovascular disease

Due to

Other Conditions: Chronic pyelitis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: Robert G. Frattali M.D.
Medical Examiner.
Date signed: Nov 26 1945

VS 151

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34518

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83 A

Registered No. G34518

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3312 Walbrook Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3312 Walbrook Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William A. Gessler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) ~~Single, married~~, widowed, or ~~divorced~~. Widowed

6 (b) Name of husband or wife Nellie Myberger

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 14, 1883

8. AGE: Years 62 | Months 4 | Days 9 | If less than one day hr. min.

9. Birthplace BALTIMORE, Md.
(Town, county, and state)

10. Usual Occupation Sprinkler fitter

11. Industry or business

FATHER
12. Name William H. Gessler
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Margaret McGuiness
15. Birthplace Baltimore, Md.

16 (a) Informant Margaret H. Gessler
(b) Address 3312 Walbrook Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/28/45 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore, Md.

18 (a) Funeral director MARTIN FAHEY & SONS
(b) Address 1827 W. North Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

NOV 27 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/25 1945, at 3 56 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/13 1945, to 11/25 1945, and that I last saw him alive on 11/24 1945.

Immediate cause of death: Cerebral hemorrhage — Duration 8 days
Due to: Hypertension — ?
Due to: Arteriosclerosis — ?
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert A. Reitz
Address 3408 Windsor Ave. Date signed 11/26/45

X -

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634519

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

634519 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: 2013 Spark Court
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2013 Spark Court (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Laura Wladyslava Pietrowski

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-14-9921

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	married

6 (b) Name of husband ~~wife~~ Vincent
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1889

8. AGE: Years	Months	Days	If less than one day
56			hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name P Schmidt
13. Birthplace unknown.

MOTHER
14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant Vincent Pietrowski
(b) Address 2013 Spark Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-27-45 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Baltimore, Md.

18 (a) Funeral director George A. Weber
(b) Address 705-9a Orin street

19 (a) Date received NOV 27 1945 (b) Registrar Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 26 1945, at 10 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert A. Graham M.D. Medical Examiner.
Date signed Nov. 26 1945

X

634520 BALTIMORE CITY HEALTH DEPARTMENT 47D 634520
CERTIFICATE OF DEATH Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 20 N Fremont Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city limits, write RURAL and give town)
(d) Street No. 20 N Fremont Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jacob F. Schafer

3 (b) If veteran, name war —
3 (c) Social Security Account No. 215-07-2367

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Anna Schafer
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 6/6/1885

8. AGE: Years 60 | Months 6 | Days 5 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business J. Baetzhold Company

FATHER 12. Name John R Schafer

13. Birthplace Md

MOTHER 14. Maiden Name Catherine Eisenbaugh

15. Birthplace Pa

16 (a) Informant Anna Schafer
(b) Address 20 N Fremont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/27/45 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore Md

18 (a) Funeral director J. B. Shipley & Son
(b) Address 1300 Eutaw Place

19 (a) (Date rec'd by registrar) (b) Registrar

NOV 27 1945 Huntington Williams, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/23/1945, 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/4 1944 to 11/23 1945
and that I last saw alive on 11/20 1945:

Immediate cause of death	Duration
Ca of Rt. Lung.	1 yr.
Cachexia.	1 yr.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel A. Bogorad M. D.
Address 1905 N. Bond St. Date signed 11/26/45

G34521

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D ✓

Registered No. G34521

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3733 Oakmont Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 7 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3733 Oakmont Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jennie Bachman

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Leopold Bachman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 25, 1861

8. AGE: Years 84 | Months 4 | Days 10 | If less than one day hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation None

11. Industry or business none

FATHER
12. Name Meyer Feuerbach
13. Birthplace Germany

MOTHER
14. Maiden Name Bertha Hartman
15. Birthplace Germany

16 (a) Informant Mrs Wm. Shipley
(b) Address 3733 Oakmont Ave

17 (a) Burial (b) Date thereof 11-28-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Hebrew Friendship
Location Baltimore Md.

18 (a) Funeral director Loring Byers.
(b) Address 5005 Park Heights Ave

19 (a) (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 25 1945, at 6:35 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1944 to Nov 25 1945 and that I last saw h[illegible] alive on Nov 25 1945.

Immediate cause of death	Duration
Arteriosclerotic Heart Disease.	10 yrs.
Due to	
Due to	
Other Conditions Uterine Fibroids	10 yrs.

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation: none
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Milton E Lamar M. D.
Address 5013 Park Heights Ave Date signed 11-25-45

VS 15 NOV 27 1945 Huntington Williams, M.D.

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634522

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30D

Registered No. 634522

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Druseland & Fayette Ave

(c) Hospital or institution: West Baltimore General Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) today

(e) Length of stay in Baltimore (yrs., mos., or days) 5yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County Baltimore

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 4536 Reisterstown Rd. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME John Anderson

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Married

6 (b) Name of husband or wife Mrs Pauline Anderson

6 (c) If alive, give age 79 years

7. Birth date of deceased (mo., day, yr.) Nov. 2 1865

8. AGE: Years	Months	Days	If less than one day
82 8 mos	1	-	hr. min.

9. Birthplace Calmar, Sweden (Town, county, and state)

10. Usual Occupation Retired Seaman

11. Industry or business

FATHER 12. Name Bondy Anderson

13. Birthplace Sweden

MOTHER 14. Maiden Name Unknown

15. Birthplace Sweden

16 (a) Informant Mrs Pauline Anderson

(b) Address 4536 Reisterstown Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-27-45 (month) (day) (year)

(c) Cemetery or crematory Lorraine Cemetery

Location Woodlawn, Md.

18 (a) Funeral director Loring Byers

(b) Address 5005 Park Heights Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

NOV 27 1945 Huntington Williams, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 25 1945, at 2 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 11 1945 to Nov 25 1945, and that I last saw him alive on Nov 25 1945

Immediate cause of death	Duration
Cardiovascular Renal Congestion Heart Failure	
Due to Hypertension Cerebrovascular Disease	
Due to Broncho Pneumonia, Bilateral	
Other Conditions Senile Arteritis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Cardiovascular Hypertension

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Russell W. Brockmeyer M. D.

Address West Baltimore General Hospital Date signed 11-25-45

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634523

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

634523 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: John Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 820 Shutter St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (Helen Mabel Payne) Helen Payne

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 4 1919

8. AGE: Years 26 | Months 10 | Days 21 | If less than one day hr. min.

9. Birthplace Gwynn Bay Virginia (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name James Payne
13. Birthplace Virginia

MOTHER
14. Maiden Name Sallie Thomas
15. Birthplace Virginia

16 (a) Informant Sallie Payne
(b) Address 820 Shutter St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Nov. 28, 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location
18 (a) Funeral director Robert L. Gorsuch
(b) Address 802 E. Carlton St.
19 (a) (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 151 NOV 27 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/25 1945, at 12:30 P M

21. I certify that I took charge of the remains described above, held an Inspection Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Tbc

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature E. H. Lubrinski M.D. Medical Examiner.
Date signed 11/26/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634524

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

634524 Registered No. 106a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Harford Rd. & Herring Run
(c) Hospital or institution: Lyden Lyden Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Charles
(c) City or town Potomac Heights
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6 Kenwood
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Larry Austin Weeks

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 2, 1943

8. AGE: Years 2 | Months 2 | Days | less than one day hr. min.

9. Birthplace Potomac Heights, Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name Milton Weeks
13. Birthplace Warrington, Virginia

MOTHER 14. Maiden Name Ruby E. Byrd
15. Birthplace Rock Gap, Virginia

16 (a) Informant father
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-28-45 (month) (day) (year)

(c) Cemetery or crematory
Location Waldorf Md

18 (a) Funeral director Hurd & Ryon
(b) Address Waldorf Md

19 (a) NOV 27 1945 (Date) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 25 1945 at 5.20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-24 1945 to 11-25 1945 and that I last saw h. alive on 11-25 1945

Immediate cause of death	Duration
Acute Tracho-bronchitis	
Due to: Diphtheria	
Due to Etiology undetermined	
Other Conditions: Congenital Cerebral Defect	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: (over)

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Melchiyah Spragens, M. D.
Address Lyden Hospital Date signed 11-25-45

634525

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 0

634525
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 603 Woodbourne Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 603 Woodbourne Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FANNY A. HELM

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife French E. Helm
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 17, 1869

8. AGE: Years	Months	Days	If less than one day
76	3	7	hr. min.

9. Birthplace Washington, D. C.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Jesse Leonard Campbell
13. Birthplace D. C.

MOTHER
14. Maiden Name Mary Catherine Root
15. Birthplace D. C.

16 (a) Informant Mr. B. Warren Merchant
(b) Address 603 Woodbourne Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/27/45 (month) (day) (year)
(c) Cemetery or crematory Govans Presby. Cem.
Location Balto.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 NOV 27 1945 (Entered by Registrar) (b) Filed Nov 26 1945 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 24, 1945, at 1:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 21 1945 to Nov. 24 1945 and that I last saw h[illegible] alive on Nov 24 1945

	Duration
Immediate cause of death Uremia	3 wks.
Due to Chr. Interstitial Nephritis	5 yrs.
Due to Arterio sclerosis	10 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Earl H. Berman, M.D. M. D.
Address 5111 York Rd Date signed Nov 26, 1945

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34526 ✓ G34526

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131 A

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 916 E. Eager St
(c) Hospital or institution: at Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 916 E. Eager St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel T. Mason

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Carrie M. Mason
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 27 1863

8. AGE: Years 82 | Months 1 | Days 28 | If less than one day: hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Retired Sloop

11. Industry or business Ropper

FATHER 12. Name Charles Mason
13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Not Known
15. Birthplace ? ?

16 (a) Informant Mrs Emma Meyer
(b) Address 916 E. Eager St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 27/45 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cemetery
Location 1400 Greenmount Ave

18 (a) Funeral director Elmer W. Conklin & Son
(b) Address 924 E. Eager St.

19 (a) (Date received by Registrar) (b) Registrar Huntington Williams

NOV 27 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 25, 1945 at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 24 1945 to Nov 25 1945 and that I last saw h[illegible] alive on Nov 24 1945

Immediate cause of death: Chronic Interstitial Nephritis — Duration

Due to: Acute Pulmonary Edema — 1 day

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward B. Wolfe
1331 North Ave Date signed 11-26-45

X

G34527

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G34527
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1906 E Federal St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town 1906 E Federal
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George A Klerlein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife Annie Klerlein
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Mar 12, 1870

8. AGE: Years	Months	Days	If less than one day
75	8	13	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation
11. Industry or business Merchant

FATHER
12. Name Gustav Klerlein
13. Birthplace Baltimore

MOTHER
14. Maiden Name Amelia E Mack
15. Birthplace Baltimore

16 (a) Informant Mrs W A Angelmeier
(b) Address 1906 E Federal

17 (a) Burial (b) Date thereof Nov 28 '45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory O'Neill Hill
Location Catonsville

18 (a) Funeral director Ulsh & Funeral Home
(b) Address 2008 Orleans

19 (a) NOV 27 1945 (b)
(Date received by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 25 1945 at 7:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 30 1944 to Nov. 25 1945 and that I last saw h/ alive on Nov. 25 1945

	Duration
Immediate cause of death: Chronic Myocarditis	2 yrs +
Due to: Chronic Arthritis	2 yrs +
Due to: Hypertrophied Prostate	2 yrs +
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature David Schneider M. D.
Address 1101 N. Milton Ave Date signed 11-26-45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34528

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G34528 55E Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 614 N. Clinton St
(c) Hospital or institution:
6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 152 N Curley (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hattie M Huber

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife John Huber

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 16 1883

8. AGE: Years 62 | Months 4 | Days 10 | If less than one day hr. min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER 12. Name George Link

13. Birthplace Germany

MOTHER 14. Maiden Name Mary J Deer

15. Birthplace Germany

16 (a) Informant John Huber

(b) Address 152 N Curley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 29 (month) (day) (year)

(c) Cemetery or crematory Oak Lawn

Location City

18 (a) Funeral director Ullrich Funeral Home

(b) Address 2008 Orleans

19 (a) (Date received by registrar) (b) Registrar

NOV 27 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 26 1945, at 7:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 30, 1945 to Nov. 26, 1945 and that I last saw h.er alive on Nov. 26, 1945

Immediate cause of death: Congestive Heart Failure — Duration: 1 day

Carcinoma of lungs (Metastasis) — 3 mos.

Due to Miltiple Myeloma — 6 months

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Philip Artigiani M. D.

Address 2942 E. Fayette St. Date signed 11/27/45

Huntington Williams, Md

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

JL - 95654 G345,29

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107 G345,29 No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 - 2
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1666 Cliftview Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Waters

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife William ( )
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 19, 1869

8. AGE: Years	Months	Days	If less than one day
76	8	6	hr. min.

9. Birthplace Washington, D. C.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John McArdle
13. Birthplace Scotland

MOTHER
14. Maiden Name Rosa McKay
15. Birthplace Scotland

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Removal (b) Date thereof Nov 25/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cem
Location Washington D C

18 (a) Funeral director Ellicott Funeral Home
(b) Address 2005 Orleans St

19 (a) (b) Huntington Wilkins

NOV 27 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 25 1945, at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 23, 1945, to Nov. 25 1945, and that I last saw h or alive on Nov. 25 1945

Immediate cause of death	Duration
Bronchopneumonia	7
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: none
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature T. P. Jernigan M. D.
Address Baltimore City Hosp. Date signed 11-25-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34530

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 R

G34530 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1010 Argyle Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1010 Argyle Ave.
(If rural give location)
(e) Citizen of foreign country (Yes or No)
If yes, name country

3 (a) FULL NAME Alice Grussum

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	c	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-19-1862

8. AGE: Years	Months	Days	If less than one day
83	8	4	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Rev. Helen Brown
(b) Address 1915 Argyle Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-27-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Md.

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

NOV 27 1945 (Date rec'd by registrar) (b) Huntington Williams Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 23 1945, at 12 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/2/1945 to 11/23/1945 and that I last saw her alive on 11/22/1945.

Immediate cause of death	Duration
Hypertensive Cardio-	
Due to Renal Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wayland K. Jones M. D.
Address 1300 N. Broadway Date signed 11/27/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634531

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

634531 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Md.
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 m a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write name of adjacent town)
(d) Street No. 713 Pearce Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harrison Lewis Matthews

3 (b) If veteran, name war: W-W. 2

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 1927

8. AGE: Years: 19 | Months | Days | If less than one day: hr. min.

9. Birthplace: Md
(Town, county, and state)

10. Usual Occupation: Laborer

11. Industry or business

FATHER
12. Name: Charles Matthews
13. Birthplace: Md

MOTHER
14. Maiden Name: Pearl Lewis
15. Birthplace: Md

16 (a) Informant: Pearl Matthews
(b) Address: 814 Pearce St.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof: 11-28-45 (month) (day) (year)
(c) Cemetery or crematory: Balto. National
Location: Balto. Md

18 (a) Funeral director: William a Jackson
(b) Address: 916 Penna Ave.

19 (a) (Date received by Registrar) NOV 27 1945 (b) Huntington Mills, Registrar, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 23, 1945 at 6:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Gunshot wounds of head with laceration of brain.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-23-45 at 6 P.M.
(b) Where did injury occur? 627 N. Eutaw St.
(c) Did injury occur at home, on farm, industrial place, in public place? friend's home. While at work? No.
(d) Means of injury Gunshot wounds.

23. Signature Benedict Skiterelis M.D.
Medical Examiner.
Date signed November 24, 1945.

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634532

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1862

Registered No. 634532

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3707 E Baltimore St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town 3707 E Baltimore St
(If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Bottemace

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Henry Bottemace
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/20/1867

8. AGE: Years 78 | Months 9 | Days 5 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation
11. Industry or business At Home

FATHER
12. Name Charles Holtz
13. Birthplace Baltimore

MOTHER
14. Maiden Name Don't know
15. Birthplace Baltimore

16 (a) Informant Mrs Helen Kolb
(b) Address 127 N. Potomac St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 29th (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location City

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2004 E. Oreans St

19 NOV 27 1945 (Date received by registrar) Registrar

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 25 1945, at 10 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from May 1945 to Nov 25 1945 and that I last saw h alive on 19

Immediate cause of death	Duration
Arteriosclerotic cardio-vascular disease	
Due to	
Due to	
Other Conditions Healing fracture of left Arm	6 wks

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence October 1 1945 M
(c) Where did injury occur? Baltimore Md
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Fall down steps

23. Signature H H Stevens
Address 3400 Erdman Ave Date signed 11/27/45

Howard J. Worden, M. D.

G34533

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 192B

G34533 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1030 Patapsco St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 3 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1030 Patapsco St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Tillie Mix

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife George F. Mix
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 5, 1875

8. AGE: Years 70 | Months 10 | Days 19 20 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Theodore Mix
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine ----------
15. Birthplace Germany

16 (a) Informant George F. Mix
(b) Address 1030 Patapsco St.

17 (a) Burial (b) Date thereof Nov. 28, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western
Location Edmondson Ave.

18 (a) Funeral director John F. Denny, Inc.
(b) Address 715 Light St.

19 (a) NOV 27 1945 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 26 1945; at 4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1945 to Nov 26 1945 and that I last saw h is alive on Nov 24 1945.

Immediate cause of death	Duration
Acute Dilatation of Heart	2 Days
Due to Mitral Regurgitation	Indefinite
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature P. E. Campbell M. D.
Address 1644 Hanover Date signed 11/27/45

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634534

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

634534 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 312 Penn St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) yr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 312 Penn St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Julia. Bridicks (Bedists Ky)

3 (b) If veteran, name war: no
3 (c) Social Security Account No.:

4. Sex: Female | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Frank. Sr
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1879

8. AGE: Years: 66 | Months: | Days: | If less than one day: hr. min.

9. Birthplace: Lith (Town, county, and state)

10. Usual Occupation: House Work

11. Industry or business:

FATHER
12. Name: ?
13. Birthplace: Lith

MOTHER
14. Maiden Name: ?
15. Birthplace: Lith

16 (a) Informant: William. Bridicks
(b) Address: 312 Penn St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Nov 27 45 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer Cem
Location: Baltimore Md

18 (a) Funeral director: Joseph Kaminskas Sons
(b) Address: 60 E Washington Ave Huntington Williamsville, W. Va.

19 (a) (b)

NOV 27 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-25 1945, at 10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-10 1945, to 11-25 1945, and that I last saw h[illegible] alive on 11-25 19 45.

Immediate cause of death: Acute Cardiac Failure — Duration: 1 da
Due to: Cerebro Vascular Renal
Due to: Disease — 17 yr
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Joseph R Kaminskas M. D.
Address: 60 W Washington Blvd Date signed: 11/26/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34535

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186 a

G34535 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1907 FLEET ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1907 FLEET ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARY C. SLITZER

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NONE

4. Sex: FEMALE
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: MARRIED
6 (b) Name of husband or wife: WILLIAM F. SLITZER
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): JUNE 6 1873

8. AGE: Years	Months	Days	If less than one day
72	5	19	hr. min.

9. Birthplace: BALTIMORE MD. (Town, county, and state)
10. Usual Occupation: HOUSE WIFE
11. Industry or business: AT HOME

FATHER
12. Name: ALBERT VAN VEEN
13. Birthplace: HOLLAND

MOTHER
14. Maiden Name: UNKNOWN
15. Birthplace: GERMANY

16 (a) Informant: PEARL HOFFMAN (DAUGHTER)
(b) Address: 1907 FLEET ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof NOV. 28/45 (month) (day) (year)
(c) Cemetery or crematory: OAK LAWN
Location: EASTERN AVE. EXT.
18 (a) Funeral director: Lilly & Zeiler inc.
(b) Address: 403 S. WOLFE ST.
19 (a) [illegible] (Date rec'd by registrar) NOV 29 1945 (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: NOV. 25 1945, at 7/30 AM.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1945 to Nov 25 1945 and that I last saw her alive on Nov 24 1945.

Immediate cause of death: coronary thrombosis — Duration 11/25/45

Due to: diabetes - 5 years —

Due to:

Other Conditions: Fracture of right femur (Surgical neck) — 11/24/45
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide: accident
(b) Date of occurrence: 11-1-45 M
(c) Where did injury occur? 1907 Fleet St. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? no
(e) Means of injury: Fell from rocking chair
23. Signature: Thos. F. Kemmerer M.D.
Address 722 N. Kenwood Ave Date signed 11/26/45

Howard J. Madeira, M.D. X 12/45

G34536

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G34536

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5308 Wendley Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5308 Wendley Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles P. Fleckenstein

3 (b) If veteran, name war: None
3 (c) Social Security Account No. 212-14-8346

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Margaret M. Smith
6 (c) If alive, give age: D years

7. Birth date of deceased (mo., day, yr.) Oct. 4th., 1868

8. AGE: Years 77 | Months I | Days 21 | If less than one day ###### min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Asst. Foreman
11. Industry or business R.C. Heller Co.

FATHER
12. Name John Fleckenstein
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Grossmann
15. Birthplace Germany

16 (a) Informant Mrs. Norman J. Martin (Daughter)
(b) Address 5308 Wendley Road.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/28/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Balto. Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) NOV 27 1945 (Date rec'd by registrar) Huntington Williams, M.D. (Registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 25th., 1945, at 3.4 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1, 1945, to Nov 25 1945; and that I last saw him alive on Nov. 24, 1945.

	Duration
Immediate cause of death: Cerebral hemorrhage	8 days
Due to: Arteriosclerosis	2
Due to:	
Other Conditions: 1 hypostatic b pneumonia	2 days

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Eugene L. Cesarino M. D.
Address 5-14 Druid Park Lane Date signed 11/26/45

Passaged

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34537

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 193D

G34537 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1417 Carrington St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1417 Carrington St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bridget T. Burns

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 10 - 1867

8. AGE: Years	Months	Days	If less than one day
78	9	14	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation —
11. Industry or business

FATHER
12. Name Lackie Burns
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary McDermott
15. Birthplace Ireland

16 (a) Informant: Miss Elizabeth Burns
(b) Address 1417 Carrington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-28-1945 (month) (day) (year)

(c) Cemetery or crematory Cathedral
Location Baltimore Md.

18 (a) Funeral director Flynn & Fleming
(b) Address 147 N. Eight St. Huntington Building Md.

19 (a) (Date rec'd by registrar) (b) Registrar

NOV 27 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 24 1945, at 5:15 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 28 1945, to Nov 1945, and that I last saw h[illegible] alive on Nov 24 1945.

Immediate cause of death	Duration
Cerebral Apoplexy	
Due to	
Due to	
Other Conditions Cystectomy & Cystostomy, Hypertension, Myocarditis	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John G. Schmeck, M. D.
Address 1337 S. Charles Date signed 11/26/45

G34538 ✓ G34538

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 130

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1447 Patapsco St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helen M. Grams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 29- 1897

8. AGE: Years 48 | Months 3 | Days 29 | If less than one day 8 hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER 12. Name Stephen C. Grams
13. Birthplace Frederick Co. Md.

MOTHER 14. Maiden Name Ellen Barrett
15. Birthplace Ireland.

16 (a) Informant Vincent F. Grams
(b) Address 1447 Patapsco St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-29-1945 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore Md

18 (a) Funeral director Flynn & Fleming
(b) Address 1476 Light St. Baltimore, Md.

19 (a) NOV 27 1945 (Registered by Registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 26 19 45 at 10:50 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute glomerular nephritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Fortune M.D. Medical Examiner.
Date signed 11/26/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34539

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G34539 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 447 E. Fort Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1310 Hanover St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Fletcher W. Benny

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Ruth A. Benny

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 19-1880

8. AGE: Years	Months	Days	If less than one day
60	5	5	hr. min.

9. Birthplace Kent Co. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Edward A. Benny

13. Birthplace —

MOTHER 14. Maiden Name Mary L. Miller

15. Birthplace

16 (a) Informant Mellie M. Jackson (Friend)

(b) Address 130 W. Orland St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-28-1945 (month) (day) (year)

(c) Cemetery or crematory Cedar Hill

Location A. A. Co. Md.

18 (a) Funeral director Flynn & Fleming

(b) Address 1426 Light St.

19 (a) Date rec'd by registrar NOV 29 1945 (b) Registrar Wilmington M.F.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 24 1945, at 8 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 29 1944, to Nov. 24 1945, and that I last saw him alive on August 1, 1945.

Immediate cause of death Coronary thrombosis — Duration immediate

Due to — Duration

Due to — Duration

Other Conditions Hypertensive cardiovascular disease — Duration 2

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Harry Deitel M. D.

Address 1226 Hanover St Date signed 11/26/45

G34540

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

G34540 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. — PENALTY FOR FINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1028 Abbott Court
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

10-27

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1028 Abbott Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LOUISA BRECHT

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None
4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Jan. 24, 1865
8. AGE: Years 80 | Months 11 10 | Days 2 | If less than one day hr. min.
9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George Brecht
13. Birthplace Germany

MOTHER
14. Maiden Name Amelia Pinneman
15. Birthplace Germany

16 (a) Informant Miss Katherine Brecht - sister
(b) Address 1028 Abbott Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-28-45 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Baltimore Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

27 1945 (b) (Date received by registrar)

Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 28 1945, at 2 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1940 to Nov 26 1945.
and that I last saw h-r alive on Nov 27 1945.

Immediate cause of death: Cardiac Insufficiency — Duration: ?
Due to: Generalized Arteriosclerosis
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel Legum M. D.
Address 1741 Eutaw Pl Date signed 11/26/45

Samuel Legum

PHYSICIAN
Underline the cause to which death should be charged statistically.

G-345401/2 BC# J40484 ✓ G-345401/2

JL - 97494

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

160C

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 20
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 min.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 253 N. Monroe St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Miedzieonowski (Nellie)

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: White
6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 25, 1945

8. AGE: Years | Months | Days | If less than one day hr. 15 min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name Nellie Miedzieonowski
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) [illegible] cremation, [illegible] (b) Date thereof 1-23-46 at 3.00 P.M.
(month) (day) (year)
(c) [illegible] crematory Baltimore City Hospitals
Location 4940 Eastern Ave

18 (a) Funeral director Baltimore City Hospitals
(b) Address Records

19 JAN 31 1946 Huntington Williams, M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 25, 1945, at 10.15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 25 1945, to Nov. 25 1945, and that I last saw him alive on Nov. 25 1945.

Immediate cause of death	Duration
Premature Separation Placenta	
Due to Prematurity	20 wks.
Self induced abortion	
Due to	
Other Conditions Premature,	2 wks

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature I. J. Bottom M. D.
Address B.C.H. Date signed 11-26-45

VS 150 Not shown on Hospital Records until Jan. 29th 1946 X

G34541

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93D

G34541
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 411 N. Linwood Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 411 N. Linwood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Francis

3 (b) If veteran, name war: NO
3 (c) Social Security Account No. 213-10-1330

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Katherine E.
6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) July 18, 1878

8. AGE: Years 67 | Months 4 | Days 17 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Baltimore Trans. Co.

11. Industry or business

FATHER
12. Name William T. Francis
13. Birthplace Baltiomore

MOTHER
14. Maiden Name Jane McKewen
15. Birthplace Baltimore

16 (a) Informant Mrs. Katherine Francis
(b) Address 411 N. Linwood Ave.

17 (a) Burial (b) Date thereof 11-28-1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Greenmount Ave. Balto.

18 (a) Funeral director H. Sander and Sons.
(b) Address North Ave & Broadway.

19 (a) 11-27-1945 (Date received by registrar) (b) Thurlington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 25 1945 at 6 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1945 to Nov 25 1945 and that I last saw him alive on Nov 25 1945

Immediate cause of death: Hypertension — Duration: 1 year
Due to: Cardiac
Due to: Vascular Disease
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address 600 N. Broadway [illegible] Nov 26 1945

VS 150

G34542

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G34542 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1235 S. Clinton St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Morris Bowen (Monroe J. Owings)

3 (b) If veteran, name war: Yes WW #1

3 (c) Social Security Account No. 212-10-1342

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife: *

6 (c) If alive, give age * years

7. Birth date of deceased (mo., day, yr.) FEB 8 1896

8. AGE: Years 49 | Months 9 | Days 18 | If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Maintenance Man

11. Industry or business Baltimore Copper Wks

FATHER
12. Name Wallace Owings
13. Birthplace Calvert Co Md

MOTHER
14. Maiden Name Mary E. Dorsey
15. Birthplace Baltimore

16 (a) Informant Mrs. Victor I Maconachy
(b) Address 4205 Euclid Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/28/45 (month) (day) (year)

(c) Cemetery or crematory Baltimore National
Location

18 (a) Funeral director Chas J. Evans Son Inc
(b) Address 118 N. Mt. Royal Ave

19 (a) NOV 27 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/25 1945, at 2 P.M.

21. I certify that I took charge of the remains described above, held an Inspection-Jury Autopsy, Inspection or Inquiry and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

25. Signature C. J. Lubinski M.D.
Medical Examiner.
Date signed 11/26/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34543
AB-97180

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G34543
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17days
(e) Length of stay in Baltimore (yrs., mos., or days) 16yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 827 Linden Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Thomas Rogers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Catherine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 3- 1921

8. AGE: Years 24 | Months 4 | Days 22 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James H. Rogers
13. Birthplace Md.

MOTHER
14. Maiden Name Maggie Joyce
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals(Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 11-29-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Drew Cathedral
Location Baltimore, Maryland

18 (a) Funeral director Charles L. Law
(b) Address 802 Madison Avenue

19 (a) (b)
(Date filed) (Registrar)
NOV 28 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 25- 1945, at 4 AM M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-8- 1945 to 11-25- 1945, and that I last saw him alive on 11-25- 1945

Immediate cause of death Pulmonary Tuberculosis — Duration 2

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert B. Copeland Jr. M.D.
Address Balt. City Hosp. Date signed 11/26/45

G34544

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 92D

G34544 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3537 Kenwick Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 60yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3537 Kenwick Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James T. Garrison

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband/wife: late Carrie Shipley

6 (c) If alive, give age 1378 Years

7. Birth date of deceased (mo., day, yr.) Aug. 14 - 1877

8. AGE: Years 67 | Months 3 | Days 13 | If less than one day ... hr. ... min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation Produce Dealer

11. Industry or business

FATHER
12. Name James Garrison
13. Birthplace Va

MOTHER
14. Maiden Name Unknown
15. Birthplace Va.

16 (a) Informant Mr. Raymond Garrison
(b) Address 1315 W. 41st St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 1 - 1945 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director Jay. L. Bleyer Jr
(b) Address 1512 Hollins St

19 (a) ... (Date rec'd by registrar) (b) Huntington Williams M.D. (Signature of registrar)

NOV 28 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 27 1945, at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1943 to Nov 27 1945, and that I last saw him alive on Oct 15 1945.

	Duration
Immediate cause of death: Cardiac dilatation	min
Due to: Arteriosclerotic cardio-vascular disease	Yrs.
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. McFaul Jr M. D.
Address 1800 N. Charles St Date signed 11/27/45

(OVER)

X

G34545

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83 ✓

G34545 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3006 Chelsea Terrace
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 d
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3006 Chelsea Terrace
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Levin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Clara

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years 75 | Months 7 | Days | If less than one day hr. min.

9. Birthplace Russia (City or town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name Not known
13. Birthplace Russia

MOTHER
14. Maiden Name Not known
15. Birthplace Russia

16 (a) Informant Clara Levin
(b) Address 3006 Chelsea Terrace

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-28-45 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philadelphia Rd & Hamilton ave

18 (a) Funeral director Jack Lewis Dir
(b) Address 1439 E Balto St

19 (a) (Date rec'd by registrar) (b) Baltimore Md

VS 15 NOV 28 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-27 1945, at 1 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/10/45 to 11/27 1945 and that I last saw h[illegible] alive on 11/27 1945.

Immediate cause of death Bronchial pneumonia — Duration 1 day
Due to
Due to
Other Conditions Cerebral hemorrhage — Duration 10 days
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] Samuel
Address 2128 W Pratt Date signed 11/27/45

107

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34546

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 E

G34546 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Maryland General Hospital
(c) Hospital or institution: 13

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 ds
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 703 N. 36th Street (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Theodore HARRY Shaffer

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Grace Shaffer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 23-1874

8. AGE: Years 71 | Months 10 | Days 3 | If less than one day hr. min.

9. Birthplace Balto County (Town, county, and state)
10. Usual Occupation Barber
11. Industry or business Retired 30 years

FATHER
12. Name Edward J. Shaffer
13. Birthplace Maryland

MOTHER
14. Maiden Name Annie Kerr
15. Birthplace Maryland

16 (a) Informant Charles Edward Shaffer
(b) Address 3509 Roland Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 29-1945 (month) (day) (year)
(c) Cemetery or crematory Mount Olivet
Location Baltimore Maryland

18 (a) Funeral director Burger Funeral Home
(b) Address 3231 Falls Road

19 (a) NOV 28 1945 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 26 1945, at 8:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-31 1945 to 11-26 1945, and that I last saw him alive on 11-26 1945.

Immediate cause of death Respiratory Failure — Duration
Due to Shock
Due to Intestinal obstruction probably from Malignancy
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 11-2-45
Major findings of operation: Intestinal obstruction from Malignancy
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. H. Frye Jr. M. D.
Address M. G. Hosp. Date signed 11-26-45

634547

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

634547 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2710 Beryl Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 1/2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DEASCED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2710 Beryl Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Doris May Simmons

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lawrence H.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 11 1911

8. AGE: Years 34 | Months 6 | Days 16 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Philip Martin

13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Grace M. Burkins

15. Birthplace Baltimore Md

16 (a) Informant Goldie Burkins

(b) Address 3308 Fait Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 30-45 (month) (day) (year)

(c) Cemetery or crematory Oak Lawn

Location Eastern Ave Rd.

18 (a) Funeral director John C Moran

(b) Address 3660 Baltimore St

19 (a) (Registrar's signature) (b)

NOV 28 1945 Registrar

Huntington Williams, Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 22 1945, at 4 00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1945 to Nov 22 1945 and that I last saw her alive on Nov 22 1945.

Immediate cause of death: Generalized Lymphosarcoma — Duration 1 3/4 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence at M

(c) Where did injury occur? —
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)

(e) Means of injury —

23. Signature Lois F. Krumrein M. D.

Address 722 N. Kenwood Ave Date signed

X 11/27/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634548

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 42B

Registered No. 631258

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 21 N. Potomac St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6'
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 21 N. Potomac St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nicholas W. Dieter

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Emma
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 10- 1870

8. AGE: Years	Months	Days	If less than one day
75	10	16	hr. min.

9. Birthplace Balto. Co (Town, county, and state)
10. Usual Occupation Balto. City Police
11. Industry or business

FATHER
12. Name Charles Dieter
13. Birthplace Balto. Co Md.

MOTHER
14. Maiden Name
15. Birthplace Balto. Co. Md.

16 (a) Informant Emma Dieter
(b) Address 21 N. Potomac St

17 (a) Burial (b) Date thereof Nov. 30-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director John A. Hogan
(b) Address 3000 E. Balto St.

19 (a) (b)
(Date received by registrar) NOV 28 1945 Registrar for Baltimore, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 26- 1945 at 2-20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1- 1945, to Nov 26- 1945, and that I last saw him alive on Nov 26- 1945.

Immediate cause of death	Duration
Cerebral Embolism	5 days
Due to Mitral Stenosis	4 yrs
Due to Myocarditis	4 yrs
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. Gill Hall M. D.
Address 1631 E North Ave. Date signed Nov 27-45

G34549

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

G34549 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33 S. Schroeder St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 33 S. Schroeder St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ernest P. Roe

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married (~~single~~, ~~widowed~~, ~~divorced~~)

6 (b) Name of husband or wife Pauline

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 11, 1901

8. AGE: Years	Months	Days	If less than one day
44	8	14	hr. min.

9. Birthplace West Virginia (Town, county, and state)

10. Usual Occupation Chauffer

11. Industry or business

FATHER
12. Name David A. Roe
13. Birthplace West Virginia

MOTHER
14. Maiden Name Isabelle Rowe
15. Birthplace West Virginia

16 (a) Informant Mrs. Elmira Warfield
(b) Address 33 S. Schroeder St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 28/45 (month) (day) (year)
(c) Cemetery or crematory Oakland Mills Cem.
Location Patapsco Highway

18 (a) Funeral director Chas. E. Howard Inc.
(b) Address 616 S. Charles St.

19 (a) NOV 28 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 25 1945, at 10:30 ~~A~~ M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 20 1945 to Nov 25 1945 and that I last saw h~~im~~er alive on Nov 25 1945.

Immediate cause of death	Duration
Exhaustion	2 Days
Due to Pulmonary Tuberculosis	4 Months
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. E. Campbell M. D.
Address 164 Hanover St Date signed 11/27/45

634550

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. 634550

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 5
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 321 E. Fornat St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Harrison

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/12/45

8. AGE: Years	Months	Days	If less than one day
	1	14	hr. min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Emmett Harrison
13. Birthplace Va

MOTHER
14. Maiden Name Magnolia Banks
15. Birthplace Va

16 (a) Informant Magnolia Bank
(b) Address 321 Forest St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/28/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Balto. County, Md

18 (a) Funeral director Joseph B. Lockard
(b) Address 1364 N. Central Ave

NOV 28 1945 (b) Huntington Milliques, M.D.
(Date received by local registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 26 19 45, at 11:30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute intestinal pneumonia

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Slaton M.D.
Medical Examiner.
Date signed 11-26-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34551 — BALTIMORE CITY HEALTH DEPARTMENT — G34551

CERTIFICATE OF DEATH

93D ✓ Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1034 N. Eutaw St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and name town)
(d) Street No. 1034 N. Eutaw Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jeanette Nelson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1901

8. AGE: Years 44 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name

FATHER 13. Birthplace Unk

MOTHER 14. Maiden Name

MOTHER 15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 30 1945 (month) (day) (year)

(c) Cemetery or crematory Mt Zion

Location Mt Zion Maryland

18 (a) Funeral director Ray W Barber

(b) Address Taylorsville, Md

19 (a) (Date received by Registrar) (b) Registrar

VS Form NOV 28 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 29 1945, at 4:45 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocarditis

Due to Electrocution

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Benedict Skiteradis M.D. Medical Examiner.

Date signed November 28, 1945.

G34552

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 634552

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2161 W.Cold Spring Lane
(c) Hospital or institution: Cold Spring Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Middleboro
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Conrad Quarengesser

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Anna Quarengesser
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar.27.1870

8. AGE: Years	Months	Days	If less than one day
75	8	0	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Frederick Quarengesser
13. Birthplace Germany

MOTHER
14. Maiden Name Katherine Kellerman
15. Birthplace Germany

16 (a) Informant Mrs.Lena Seward
(b) Address 7817 Phila Road

17 (a) Burial (b) Date thereof Nov.29/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt.Carmel Cem.
Location Balto. Md.

18 (a) Funeral director Philip Henry Sons
(b) Address 2024 Orleans St.

19 (a) (Date received) (b) Huntington Williams, M.D. Registrar

NOV 29 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov.27/45 19 , at 7 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov.7 1945 to Nov.27 1945 and that I last saw h. alive on Nov 23 1945

Immediate cause of death Chronic Nephritis

	Duration
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature M. H. Cutterman M.D.
Address 2224 Reisterstown Rd Date signed 11/27/45

G34553

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. G34553

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Josephs Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 da
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1748 Bank St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME. Martin Frank Baranowski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Hazel
6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) Sept. 25, 1892

8. AGE: Years	Months	Days	If less than one day
53	2	1	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Bartender
11. Industry or business —

FATHER
12. Name Martin Baranowski
13. Birthplace Poland

MOTHER
14. Maiden Name Sophie Gierz
15. Birthplace Poland

16 (a) Informant Mrs. Hazel Baranowski
(b) Address 1748 Bank Street

17 (a) Burial (b) Date thereof 11/30/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Mt. Carmel Road

18 (a) Funeral director M. J. Sedorshot Sons
(b) Address 1518 Eastern Ave

19 (a) [illegible] Washington Williams
(Date received by registrar) Registrar

NOV 28 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-26 1945, at 11:39 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-25 1945, to 11-26 1945, and that I last saw him alive on 11-26 1945.

Immediate cause of death — Duration

Cardio-Respiratory Failure

Due to Bilateral Lobar Pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. E. Robertson M. D.
Address St. Josephs Hosp Date signed 11-27-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634554

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 634554

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 50a
(e) Length of stay in Baltimore (yrs., mos., or days) 52

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2201 E. Pratt St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Alexandria (ALICE) Barczak

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Henry

6 (c) If alive, give age 79 years

7. Birth date of deceased (mo., day, yr.) 2/16/77

8. AGE: Years 68 | Months 9 | Days 9 | If less than one day ____ hr. ____ min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Ludwike Wilke

13. Birthplace Poland

MOTHER 14. Maiden Name Mary Buziak

15. Birthplace Poland.

16 (a) Informant Mr. Henry Barczak

(b) Address 2201 E. Pratt Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/29/45 (month) (day) (year)

(c) Cemetery or crematory St. Stanislaus

Location Mt. Carmel Road

18 (a) Funeral director M. J. Nelson Sons

(b) Address 1808 Eastern Avenue

19 (a) ____ (b) ____ (Date received by registrar)

NOV 28 1945

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 25 1945 at 10:46 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocarditis Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury ____ at ____ M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? ____ While at work? ____

(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.

Date signed Nov. 25 1945

X

634555

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

Registered No. 634555

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRINT WHITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1010 Rutland Avenue
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Daniel Richardson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan. 2, 1914

8. AGE: Years 31 | Months 10 | Days 22 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Daniel J. Richardson
13. Birthplace Bermuda Isle

MOTHER
14. Maiden Name Drucella Lomax
15. Birthplace Md

16 (a) Informant Mrs. Gertrude Austin
(b) Address 231 Douglas Court

17 (a) Burial (b) Date thereof 11/29/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk
Location.....

18 (a) Funeral director Ebony O. Wilson
(b) Address 1000 Bridgeley ave

NOV 28 1945 (Date received by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 28, 1945, at 8:55 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet Wounds of Chest.

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-24-45 8:35 P.M.
(b) Where did injury occur? Waldo Court
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No.
(d) Means of injury Shooting

23. Signature Paul G. Fisher M.D.
Medical Examiner.
Date signed Nov. 26 1945

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634556
484277

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH
157 E

Registered No. 634556

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State..... (b) County.....
(c) City or town Washington - D. C.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2720 Wisconsin Ave. N.W.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Betty Ruth Eckert

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife.....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 2-5-42

8. AGE: Years	Months	Days	If less than one day
3	9	22	..... hr. ..... min.

9. Birthplace Washington - D. C.
(Town, county, and state)

10. Usual Occupation.....
11. Industry or business

FATHER
12. Name Milton K Eckert
13. Birthplace Mr.

MOTHER
14. Maiden Name Edith Scottshall
15. Birthplace Pa

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (b) Date thereof 11/28/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory.....
Location Washington, D. C.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address North & Penna. Aves

NOV 28 1945
(Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION P

20. DATE OF DEATH Nov. 27 1945 at 10.55 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 26 1945 to Nov. 27 1945 and that I last saw h.... alive on Nov. 27 1945

Immediate cause of death Unknown — Post-operative cerebral complication — Duration

Due to Cong. Malf. of Heart — Embolism

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

Date of operation 11/27/45

Major findings of operation: Path. Stenosis

of autopsy: (If any)

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....

23. Signature Helen B Taussig M.D.
Address Johns Hopkins Hospital Date signed 11/28/45

G34557

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 622

G34557 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 300 S. Augusta Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) 1 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 300 S. Augusta Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sue Darlene Spiker

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 19. 1943

8. AGE: Years	Months	Days	If less than one day
2	3	8	hr. min.

9. Birthplace Blackwater Va
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name James Spiker
13. Birthplace Pa

MOTHER 14. Maiden Name Eula G. Goins
15. Birthplace Va.

16 (a) Informant Anita M. Goins
(b) Address 300 S. Augusta Ave.

17 (a) Burial (b) Date thereof Nov. 29. 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location City

18 (a) Funeral director Mrs. Mrs. John W. Teufel & Son
(b) Address 201 W. Fayette St.

(a) NOV 28 1945 (b)
(Date filed by Registrar)

Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 27 1945 at 9 45 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 7 1945 to Nov 27 1945, and that I last saw her alive on Nov 27 1945.

Immediate cause of death Wilms Tumor C
General Metastasis

	Duration
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Elliot W Johnson M. D.
Address 3432 Druid Park Date signed 11/29/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34558

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 830

G34558 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 507 Otterbein St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ernest F. Kuehn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 5. 1868

8. AGE: Years	Months	Days	If less than one day
77	2	22	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation unemployed

11. Industry or business

FATHER
12. Name Herman Kuehn
13. Birthplace Germany.

MOTHER
14. Maiden Name Caroline Schaper
15. Birthplace Germany

16 (a) Informant Lena D. Kuehn
(b) Address 815 Scott St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 29. 1945 (month) (day) (year)
(c) Cemetery or crematory Western
Location City

18 (a) Funeral director Mr. Mrs. John W. Deufel & Son
(b) Address 801 W. Lafayette Ave Williamsport, Md.

19 (a) Filed NOV 28 1945 (b) Thurlington for Williamsport, Md. (Date filed) (Signature of registrar) Registrar

V8 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27 1945, at 9:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3 P.M. 11-27 1945 to 9:20 P.M. 11-27 1945, and that I last saw him alive on 11-27 1945.

Immediate cause of death Cerebral accident

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles Butler M. D.
Address Univ. Hosp. Date signed 11-27-45

For P.H.S. McNally by Howard J. Weaver, M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Md. G34559

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 159

G34559
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St.
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6Hrs. 50Min.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Severn - Rural (If outside city or town limits, write RURAL and give town)
(d) Street No. New Cut Road, 2 K. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME. Eleanor Tepper

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: F.
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 11-27-45
8. AGE: Years No. Months No. Days No. If less than one day: 6 hr. 50 min.
9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Carl Louis Tepper
13. Birthplace Severn Md.

MOTHER
14. Maiden Name Martha Anna Harvaitt
15. Birthplace Baltimore Md.

16 (a) Informant L. Tepper
(b) Address Severn Md R.F.D.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 29 45 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Anne Arundel Co. Md.

18 (a) Funeral director Thomas A Singleton
(b) Address Glen Burnie, Md

NOV 28 1945 (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/28/45 19 , at 6:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/21 1945 to 11/28 1945 and that I last saw h IN alive on 11/28 1945

Immediate cause of death	Duration
Respiratory Collapse	
Due to Incomplete development of body organs	
Due to Prematurity	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. L. Strickland Jr. M. D.
Address Bon Secours Hosp. Date signed 11/28/45

VS 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34560

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 53

G34560 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Lombard & Green

(c) Hospital or institution: University

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo. 10 d

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State N.C. (b) County

(c) City or town Selma (If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Ralph McGlathlin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race [illegible] | 6 (a) Single, ~~married, widowed, or divorced~~

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1926

8. AGE: Years 19 | Months | Days | If less than one day hr. min.

9. Birthplace Selma, N.C. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Brady McGlathlin

13. Birthplace N.C.

MOTHER 14. Maiden Name Stella Gregory

15. Birthplace N.C.

16 (a) Informant Father

(b) Address Selma, N.C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 28 1945 (Month) (Day) (Year)

(c) Cemetery or crematory West Lawn

Location Oxford Road

18 (a) Funeral director John O. Mitchell Sons

(b) Address 1400 Eutaw Place

19 (a) (Date received by local registrar) NOV 28 1945 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-27 1945, at 2.57 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-27 1945 to 11-27 1945, and that I last saw h[illegible] alive on 11-27 1945

Immediate cause of death: Asphyxia, Strangulation — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation [illegible] 10-22-45

Major findings of operation: None

of autopsy: Asphyxia

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(d) Means of injury

23. Signature [illegible]

Address Univ. Hosp. Date signed 11-27-45 M. D.

X

G34561 Fansler G34561

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1131a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 643 S. Newkirk St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26-
(e) Length of stay in Baltimore (yrs., mos., or days) 3 mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va. (b) County Berkeley
(c) City or town Martinsburg W. Va.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 411 W. John St
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Johanna Ruth Fansler

3 (b) If veteran, name war: no
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	single

6 (b) Name of husband or wife:
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 26, 1894

8. AGE: Years	Months	Days	If less than one day
51	10	2	hr. min.

9. Birthplace Oregon, born Monroe Co. W. Va.
(Town, county, and state)
10. Usual Occupation
11. Industry or business Sales lady

FATHER
12. Name Joseph Fansler
13. Birthplace Virginia

MOTHER
14. Maiden Name Julia Ann Boggs
15. Birthplace W. Va.

16 (a) Informant Mrs. W. G. Hulk (Brother-in-law)
(b) Address 643 S. Newkirk St (24) 3600 Eastern

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 1, 1945 (month) (day) (year)
(c) Cemetery or crematory Green Hill Cem.
Location Martinsburg, W. Va.

18 (a) Funeral director C. Howard Evans
(b) Address 1400 S. Charles St. Balto 30

19 (a) (Date rec'd by registrar) NOV 28 1945 (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 28 1945, at 10.00 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1945 to Nov. 28 1945, and that I last saw h.. alive on Nov. 27 1945.

Immediate cause of death Myocardial Failure — Duration: 7yrs

Due to Hypertensive Cardio-Vascular Renal Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

PHYSICIAN
Underline the cause to which death should be charged statistically.

23. Signature C. Howard Evans M. D.
Address Liberty Parkway (Dundalk) Date signed 11-28-45

D. Bubert
4803 Parkhurst Ave
G34562

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH
83a

G34562 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3114 Woodland Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3114 Woodland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine A. Kellermann

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife Anthony M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 29 - 1860

8. AGE: Years	Months	Days	If less than one day
84	11	27	hr. min.

9. Birthplace Washington D C.
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Joseph Roth
13. Birthplace Bavaria

MOTHER
14. Maiden Name Catherine Simon
15. Birthplace Washington D.C.

16 (a) Informant Miss Catherine Kellermann
(b) Address 3114 Woodland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 29 45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location

18 (a) Funeral director E. L. Ruck
(b) Address 5305 Harford Rd

19 (a) 28 1945 d by registrar (b) Evington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 26 1945; at 2 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 26 1945 to Nov 26 1945 and that I last saw h alive on Nov 26 1945

Immediate cause of death	Duration
Cerebral Hemorrhage	11/26/45
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John D. Bubert M. D.
Address 4803 Park Heights Ave Date signed 11/27/45

G34563

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G34563 / 45F

Registered No. _____

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address _____
(c) Hospital or institution: Mercy Hosp 21
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED: 6
(a) State Md. (b) County _____
(c) City or town Baltimore - 14 (If outside city or town limits, write RURAL and give town)
(d) Street No. 6409 Hartford Rd. (If rural, give location)
(e) Citizen of foreign country? Nat (Yes or No)
If yes, name country _____

3 (a) **FULL NAME** George Archer Clayton Sr.

3 (b) If veteran, name war _____ | 3 (c) Social Security Account No. _____

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Della B. Clayton
6 (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) July 9 1885

8. AGE: Years	Months	Days	If less than one day: hr.	min.
57	4	18		

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business Canton Coke & Coal

FATHER
12. Name Wells A. Clayton
13. Birthplace Maryland

MOTHER
14. Maiden Name _____
15. Birthplace _____

16 (a) Informant Mrs. Della B. Clayton
(b) Address 6409 Hartford Rd!

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 - 45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto

18 (a) Funeral director Leonard J. Rucker
(b) Address 5305 Harford Rd.

19 (a) 1945 (Filled in by registrar) (b) _____ Registrar

Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/27 1945, at 8:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/26 1945 to 11/27 1945, and that I last saw h[illegible] alive on 11/27 1945

Immediate cause of death	Duration
Massive Hemorrhage	
Due to Lymphosarcoma of Stomach	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation _____
Major findings of operation: _____
of autopsy: _____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide _____
(b) Date of occurrence _____ at _____ M
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature Charles Stuckey Jr. M.D.
Address Mercy Hosp. Date signed 11/29/45

VS 150

634564

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55 B

634564

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Joseph's Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 34 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Frederick
(c) City or town Emmitsburg
(If outside city or town limits, write RURAL and give town)
(d) Street No. — (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George F. Eckenrode

3 (b) If veteran, name war: —
3 (c) Social Security Account No.:

4. Sex: M | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife:
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) Aug. 9 1873

8. AGE: Years 72 | Months 3 | Days 18 | If less than one day: hr. — min.

9. Birthplace St. Anthony Md
(Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business

FATHER
12. Name Henry J. Eckenrode
13. Birthplace Adams Co. Pa

MOTHER
14. Maiden Name Margaret A. Roddy
15. Birthplace Adams Co. Pa

16 (a) Informant John A. Eckenrode
(b) Address Baltimore Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/1/45 (month) (day) (year)
(c) Cemetery or crematory St. Anthony
Location St. Anthony Frederick Co. Md

18 (a) Funeral director M. J. Quaglino Sons
(b) Address Emmitsburg Md

19 (a) (Date received by Registrar) NOV 28 1945 Huntington Williams Md Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-27 1945, at 8:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-24 1945 to 11-27 1945, and that I last saw h— alive on 11-27 1945

Immediate cause of death	Duration
Cardio-Respiratory Failure	
Due to: Terminal Pneumonia (Lobar)	
Due to:	
Other Conditions: Terminal Pneumonia, Probable osteogenic Sarcoma	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. E. Robertson M. D.
Address St. Joseph's Hosp Date signed 11-27-45

G34565
484045

BALTIMORE CITY HEALTH DEPARTMENT X
CERTIFICATE OF DEATH 52 B

G34565

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Frederick
(c) City or town Middletown
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles E. Cassell

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male.	White	married

6 (b) Name of husband or wife Janet.
6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) 9-2-78

8. AGE: Years	Months	Days	If less than one day
67	9	26	..... hr. ..... min.

9. Birthplace Piedmont Md (Town, county, and state)
10. Usual Occupation Printing
11. Industry or business

FATHER
12. Name Charles E Cassell
13. Birthplace Md.

MOTHER
14. Maiden Name Julia B Foreman
15. Birthplace Md.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/1/45 (month) (day) (year)
(c) Cemetery or crematory United Brethren
Location Thurmont Md.

18 (a) Funeral director M. L. Biggs Store
(b) Address Thurmont Md

19 (a) NOV 28 1945 (Date rec'd by registrar) Huntington [illegible], Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-28- 1945, at 12 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov-21 1945, to Nov-28 1945 and that I last saw him alive on Nov-28 1945

Immediate cause of death Uremia	Duration
Due to Pyelonephritis, Right Perinephric abscess et	
Due to Ureteral Stricture right non-functioning Kidney & Bladder	
Other Conditions Carcinoma of Bladder 2 Total Cystectomy - 1943 (Include pregnancy within 3 months of death)	

Date of operation 11-22-45
Major findings of operation Pyelonephritis, Rt. Perinephric abscess, Rt.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herbert S. Donahoe M. D.
Address Johns Hopkins Hosp Date signed 11-28-45

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634566

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

634566
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 Cold Spring Lane
(c) Hospital or institution: Cold Spring Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1909 Greenmount Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maurice J. Frederick

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: 213-05-0474

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Jane Stulty Frederick

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 28, 1881

8. AGE: Years: 64 | Months: 9 | Days: 29 | If less than one day: hr. min.

9. Birthplace: Howard Co., Md.
(Town, county, and state)

10. Usual Occupation: Slubber operator

11. Industry or business: Hooper Cotton Duck Mill

FATHER
12. Name: Aquilla Frederick
13. Birthplace: Howard Co., Md.

MOTHER
14. Maiden Name: Annie C. Gallagher
15. Birthplace: Unknown

16 (a) Informant: Mrs. Nellie R. Causey
(b) Address: Dorchester, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Nov. (month) (day) 1945 (year)

(c) Cemetery or crematory: St. Mary's
Location: Dorchester, Md.

18 (a) Funeral director: Easton Sons
(b) Address: Ellicott City, Md.

(a) NOV 28 1945 (b)
Date received by registrar — Registrar

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 26, 1945 at 7:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 8 1945, to Nov. 26 1945, and that I last saw h.... alive on Nov. 23 1945.

Immediate cause of death: cerebral hemorrhage — Duration:

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: M. H. Cutterman M. D.

Address 2324 Reisterstown Rd Date signed 11/28/45

Huntington Williams, M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34567

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G34567

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2518 W. Fairmount Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 1/2 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2518 W. Fairmount Ave.
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Grace Margaret Arnold

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife:
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.): October 9, 1888
8. AGE: Years 57 | Months 1 | Days 19 | If less than one day: hr. min.
9. Birthplace: Maryland (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business: Invalid 16 yrs.

FATHER
12. Name: ? Powers
13. Birthplace: Unknown

MOTHER
14. Maiden Name: ? Cole
15. Birthplace: Unknown

16 (a) Informant: Elizabeth E. Shriver
(b) Address: 2518 W. Fairmount Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-30-45 (month) (day) (year)
(c) Cemetery or crematory: Baltimore
Location: Baltimore, Maryland

18 (a) Funeral director: Geo. L. Pelham
(b) Address: 2101 Frederick Avenue

19 (a) [illegible] registrar: Huntington Williams, M.D. Registrar

NOV 29 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH November 28, 1945, at 3:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 17 1944, to Nov. 28 1945, and that I last saw her alive on Nov. 28, 1945.

Immediate cause of death: Cardiac failure — Duration: 2 yrs
Due to: hypertensive cardio vascular disease
Due to:
Other Conditions: Extreme hypertrophic arthritis deformans — Duration: 2
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Harry Deller, M.D.
Address: 1326 Hanover St. Date sig

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634568

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 D

634568 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1702 Greenmount Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1702 Greenmount (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Conrad Heatherich

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: none

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Rosie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): May 4 1865

8. AGE: Years: 80 | Months: 6 | Days: 24 | If less than one day: hr. min.

9. Birthplace: Baltimore Md (Town, county, and state)

10. Usual Occupation: Retired Business Man

11. Industry or business: Self

FATHER
12. Name: Henry Heatherich
13. Birthplace: Germany

MOTHER
14. Maiden Name: Elizabeth Stuphy
15. Birthplace: Md

16 (a) Informant: Rosie Heatherich
(b) Address: 1702 Greenmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-29-45 (month) (day) (year)
(c) Cemetery or crematory: London Park
Location: Baltimore Md

18 (a) Funeral director: Tillman Funeral Home Inc
(b) Address: 1211 E Lanvale St

19 (a) NOV 29 1945 (Date rec'd by registrar) Huntington Millemann, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 28 1945, at 9:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 19 1945 to Nov 28 1945 and that I last saw h[illegible] alive on Nov 27 1945

Immediate cause of death: Generalized Arteriosclerosis and Hypertensive Heart Disease — Duration: 5 Yrs.

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Philip D. Flynn M.D.

Address 1800 N. Charles St. Date signed Nov 28 1945

X Flynn

634569

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

832

634569 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 727 Edmondson Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 727 Edmondson Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Emma W Haines

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Chas W Maryland Haines
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 22 1864

8. AGE: Years 80 | Months 11 | Days 4 | If less than one day hr. min.

9. Birthplace Syracuse N. Y. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Joseph Whitehead
13. Birthplace England

MOTHER 14. Maiden Name Ann(Ann) Farley
15. Birthplace England

16 (a) Informant Porter H. Haines
(b) Address 1016 N Belvedere Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/29/45 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Baltimore Md

18 (a) Funeral director Hillcoat & Co Inc
(b) Address 1217 E Fort Ave

19 NOV 29 1945 (Date rec'd by Registrar) Huntington Hillcoat, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 26 1945 at 4:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 27 1945 to Nov 26 1945 and that I last saw h[illegible] alive on Nov 25 1945

Immediate cause of death: Cerebral Hemorrhage — Duration 2 wks.
Due to: Arteriosclerosis — 10 yrs.
Due to: Senility — 10 yrs.
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. S. Chalfont M.D.
Address 610 York Rd Date signed Nov 27 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34570

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 77D

Registered No. G34570

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2242 W. Baltimore St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Jeraldine Haugh

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Earl Haugh

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 10, 1903

8. AGE: Years 41 Months 11 Days 15 If less than one day hr. min.

9. Birthplace Georgia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name George Jones

13. Birthplace Georgia

MOTHER 14. Maiden Name Mary Cohen

15. Birthplace Georgia

16 (a) Informant

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/29/45 (month) (day) (year)

(c) Cemetery or crematory Lorraine Park Cem.

Location Woodlawn, Md.

18 (a) Funeral director Harry H. Witzke

(b) Address 4101 Edmondson Ave.

19 NOV 29 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 26 1945, at 5:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 22 1945, to Nov. 26 1945, and that I last saw her alive on Nov. 26 1945.

Immediate cause of death	Duration
Acute Pulmonary Tumors	
Due to Chronic Alcoholism	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas E. Wheeler M. D.

Address South Balto. Gen. Date signed 11/26/45

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

631571

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47D

631571
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4414 Ethland Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4414 Ethland Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Irwin Manning Brown

3 (b) If veteran, name war: none

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Carrie G. Brown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 25, 1884

8. AGE: Years 61 | Months 9 | Days 2 | If less than one day hr. min.

9. Birthplace Fernwood, Balto. Co., Md.
(Town, county, and state)

10. Usual Occupation Insurance Business

11. Industry or business

FATHER
12. Name George Brown
13. Birthplace Brookland Wood, Md.

MOTHER
14. Maiden Name Frances Winchester
15. Birthplace Balto. Co., Md.

16 (a) Informant Mrs. Carrie G. Brown
(b) Address 4414 Ethland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/29/45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b)

NOV 29 1945

Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27, 1945, at 8:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 24 1945 to Nov. 27 1945. and that I last saw him alive on Nov. 26 1945

Immediate cause of death: Carcinoma of the Lung — Duration: 8 mos.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Warren A. Allan M. D.
Address 6 E Eager St. Date signed 11-28-45

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34572

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

125a

Registered No. G34572

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1520 E. Eager Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and name town)
(d) Street No. 1520 E. Eager Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Gordon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1908

8. AGE: Years 37 | Months | Days | If less than one day hr. min.

9. Birthplace N. C.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknow
15. Birthplace

16 (a) Informant John Gordon
(b) Address 1520 E Eager St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-29-45 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary
Location A. A. Co

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E Preston St

19 NOV 29 1945 (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 26 1945, at 8:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Hemorrhagic nephritis.
Acute yellow atrophy of liver.
Due to: Rheumatic Endocarditis.
Cerebral edema, marked.
Other Conditions Confluent lobular pneumonia.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skitarelic M.D.
Medical Examiner.
Date signed November 27, 1945.

VS 151

634573 ✓ 634573

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Edward & Greene
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) probably - 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md.: (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 116 East Preston
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leo Kohler (Leopold J. Kohler)
3 (b) If veteran, name war
3 (c) Social Security Account No. 213-03-6473

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 30 1880

8. AGE: Years 65 | Months 1 | Days 28 | If less than one day hr. min.

9. Birthplace Hungary (Town, county, and state)
10. Usual Occupation Chef for Miller Bros
11. Industry or business for 18 years.

FATHER
12. Name Conrad Rohrabacher
13. Birthplace " " " "

MOTHER
14. Maiden Name " " " "
15. Birthplace " " " "

16 (a) Informant Mr. F. J. Ciotti (atty)
(b) Address 1107 Mercantile Trust & Dep. Co. Bldg

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 30 45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore

18 (a) Funeral director Stewart & Mages Co.
(b) Address 1010 North Ave.

19 NOV 29 1945 (Registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-27 1945 at 12 45 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-26 1945 to 11-27 1945 and that I last saw him alive on 11-27 1945

Immediate cause of death	Duration
Cardiac Failure	
Respiratory Failure	
Due to Generalized arteriosclerosis.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. Dorsey Clark M. D.
Address University Hosp Date signed 11-27

VS 3

Please write plainly, with ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634574

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1572

Registered No. 634574

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount Ave.
(c) Hospital or institution:
Church Home & Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ days
(e) Length of stay in Baltimore (yrs., mos., or days) 1½ days.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1849 N. Edison Park Ave. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Auchwald

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Single (N.B.)

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/26/45

8. AGE: Years | Months | Days: 1½ | If less than one day: hr. min.

9. Birthplace Baltimore, Md. Balt. Co.
(Town, county, and state)

10. Usual Occupation New Born
11. Industry or business N. B.

FATHER
12. Name Paul Karl Auchwald
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Ruth Elizabeth Birmingham
15. Birthplace Baltimore, Md.

16 (a) Informant Father
(b) Address above

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 29/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore Lawn
Location North Ave & Gay St

18 (a) Funeral director John G. Miller
(b) Address 2334 Jefferson St.

19 (a) (b)
(Date rec'd by registrar) Registrar

NOV 29 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 28 1945 at 2 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/26 1945 to 11/28 1945, and that I last saw h[illegible] alive on 11/27 1945.

	Duration
Immediate cause of death: Congenital Heart Disease	1½ days
Due to:	
Due to:	
Other Conditions: Pulmonary [illegible] Congestion	1½ days

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Congenital Heart Disease.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Conrad M. Lummus M.D.
Address Church Home & Hosp. Date signed 11/29/45

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634575

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

634575 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 915 S.POTOMAC
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County BALTO.
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 915 S.POTOMAC ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: FRANCES P.ADAMS

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NONE

4. Sex: FEMALE
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: WIDOW

6 (b) Name of husband or wife: JAMES J.ADAMS
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): MAR.5 1843

8. AGE: Years 102 | Months 9 | Days 24 | If less than one day hr. min.

9. Birthplace: VIRGINIA (Town, county, and state)
10. Usual Occupation: HOUSE WIFE
11. Industry or business: AT HOME

FATHER
12. Name: FRANKLIN JARVIS
13. Birthplace: VA.

MOTHER
14. Maiden Name: MARY HUTCHENS
15. Birthplace: VA.

16 (a) Informant: JOHN ADAMS (SON)
(b) Address: 915 S.POTOMAC ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof NOV. 29/45 (month) (day) (year)
(c) Cemetery or crematory: OAK LAWN CEM.
Location: EASTERN AVE EXT.

18 (a) Funeral director: Lilly & Zeiler inc.
(b) Address: 403 S.WOLFE ST.

19 (a) NOV 29 1945 (b) [illegible] for Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH NOV.26 1945 at 1/15 PM.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1942 to Nov. 26 1945, and that I last saw h.R.t. alive on Nov. 16 1945.

Immediate cause of death: Chronic Myocarditis — Duration: Unknown
Due to: Senile Marasmus — Duration: Unknown
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: J.A. Rosenblatt M. D.
Address: 3018 O'Donnell St. Date signed: 11-27-45

634576

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1611

Registered No. 634576

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution University Hospital W
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 d.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 524 W. Conway St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry J. Hamlin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/22/45

8. AGE: Years | Months: 1 | Days: 5 | If less than one day: hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name Sylvester Hamlin
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Priscilla Harris
15. Birthplace Va

16 (a) Informant Priscilla Hamlen (M)
(b) Address 524 W. Conway St.

17 (a) Burial (b) Date thereof 11-29-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Auburn
Location Balto City

18 (a) Funeral director Isaiah L Brown & Son
(b) Address 108 W Montgomery St

NOV 29 1945
(Date rec'd by registrar) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 27 1945, at 7 pm M

21. I certify that I took charge of the remains described above, held an Inspection + Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Upper respiratory infection.

Due to

Other Conditions Marked dehydration

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Benedict Skotarelic M.D.
Medical Examiner.

Date signed November 28, 1945.

correct age is especially important. Physicians: please write the c

G34577 ✓ X G34577

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94 Q Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Leroy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Va. (b) County
(c) City or town Norfolk (If outside city or town limits, write RURAL and give town)
(d) Street No. 8901 Hampton Blvd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph A. Fulford

3 (b) If veteran, name war —
3 (c) Social Security Account No. 156-01-2252

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 27-1902

8. AGE: Years	Months	Days	If less than one day
43	4	2	hr. min.

9. Birthplace Burford County - N.C. (Town, county, and state)
10. Usual Occupation Merchant Seaman
11. Industry or business

FATHER
12. Name Joseph N. Fulford
13. Birthplace Burford County N.C.

MOTHER
14. Maiden Name Martha Rose
15. Birthplace Burford County - N.C.

16 (a) Informant Francis A. Gay
(b) Address South Norfolk Va.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 3-1945 (month) (day) (year)
(c) Cemetery or crematory Riverside Memorial
Location Norfolk Va

18 (a) Funeral director Ellsworth Armacost
(b) Address 3911 Liberty Heights Ave

19 (a) NOV 29 1945 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27 1945, at 10 20 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Proctor M.D. Medical Examiner.
Date signed Nov. 27 1945

VS 151

Hunter Williams, M.D.

G34578

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G34578

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2513 W. Lombard St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) 71 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2513 W. Lombard St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick Krammes

3 (b) If veteran, name war —

3 (c) Social Security Account No. 215-05-6469

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widowers

6 (b) Name of husband or wife Mary C. Krammes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 4 - 1874

8. AGE: Years	Months	Days	If less than one day
71	10	22	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Machine Operator
11. Industry or business Bristle factory

FATHER
12. Name Unknown
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Wilbert J. Krammes
(b) Address 534 S. Catherine ST

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 30-1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location Baltimore - Md.

18 (a) Funeral director Leonard L. Covington
(b) Address 21 W. 25th ST

NOV 29 1945 (Date received by local registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-26 - 1945 at 5:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1945 to 11-26 1945 and that I last saw him alive on 11-26 1945.

Immediate cause of death: Cerebral Hemorrhage — Duration 2 months.
Due to: Generalized arteriosclerosis — ? .
Due to: — — .
Other Conditions: — — .
(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature Wm B. Schmeisser M. D.
Address 574 S. Fulton Ave Date signed 11-28-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634579

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157E

634579 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 804 Jack St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John N. Poppas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Baby

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 28, 1945

8. AGE: Years	Months	Days	If less than one day
	1	29	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Nick Poppas
13. Birthplace Cyprus Island

MOTHER
14. Maiden Name Lillian Gonsalves
15. Birthplace West Indies

16 (a) Informant Nick Poppas
(b) Address 804 Jack St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 29-1945 (month) (day) (year)
(c) Cemetery or crematory Greek Orthodox Cem
Location Baltimore, Md

18 (a) Funeral director Leonard A. Covington
(b) Address 21 W. 26th St

19 (a) Date received ~~MAY 29 1945~~ (b) Huntington Williamsburg Md

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH November 27, 1945 at 1:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 27, 1945 to Nov. 27, 1945 and that I last saw him alive on Nov. 27, 1945.

Immediate cause of death	Duration
Cardiac failure	
Due to Myocardial insufficiency	
Due to Congenital heart disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Cong. H. D. Aortic stenosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert J. Weiss M. D.

Address Sinai Hospital Date signed 11/28/45

X

G34580

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH / 3B

G34580 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 512 W. Cross
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days) 35

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 512 W. Cross
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John W. Vaughn

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife Grace Vaughn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 1. 1889

8. AGE: Years	Months	Days	If less than one day
56 55	8	26	hr. min.

9. Birthplace Cambridge Md
(Town, county, and state)
10. Usual Occupation
11. Industry or business Transfer. Owner

FATHER
12. Name Benj. Vaughn
13. Birthplace Md

MOTHER
14. Maiden Name Hattie Allen
15. Birthplace Md

16 (a) Informant Grace Vaughn
(b) Address 512 W. Cross St

17. (a) Burial (b) Date thereof Nov 2 - 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director James A Stayton
(b) Address 1422 W Lies St

19 (a) (b)
Registrar

NOV 29 1945 Washington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27 1945 at 2:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/1 1945 to 11/27 1945 and that I last saw h[illegible] alive on 11/20 1945

Immediate cause of death	Duration
Pulmonary	
Due to TB	4 mos
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 1123 Hanover Date signed 11/28/45

634581

CHK-27504

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

56 C ✓

Registered No. 634581

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Give the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 4 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1501 Linden Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ruth Morton

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 19-1908

8. AGE: Years 37 | Months 4 | Days 7 | If less than one day hr. min.

9. Birthplace Illinois (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Archibald Morton
13. Birthplace Scotland

MOTHER
14. Maiden Name Adele Schultze
15. Birthplace Indiana

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/2/45 (month) (day) (year)
(c) Cemetery or crematory Chrysler Am.
Location Chrysler Lake, Ill.

18 (a) Funeral director Selby & Gilson Co.
(b) Address 403 S. Holt St.

(a) Filed NOV 29 1945 (Registrar) (b) Registered by (Registrar) Huntington Williams M.D.

VS 150

Subject to approval of Medical Examiner Benedict Shiarella Jr. M.D.

MEDICAL CERTIFICATION

P

20. DATE OF DEATH November 26 1945, at 8:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 26 1945, to Nov. 26 1945, and that I last saw her alive on Nov. 26 1945.

Immediate cause of death	Duration
Uterine hemorrhage	1 mo.
Due to Gangrene of cervix	1 mo.?
Due to Pelvic infection cause unknown	1 mo.?
Other Conditions —	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: { as above, + pelvic cellulitis + hematoma of vagina

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas J. O'Neill M. D.
Address Balto. City Hospo Date signed 11-27-45

PHYSICIAN
Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

631582

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

631582 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1307 W. Pratt St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1307 W. Pratt St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret J. Kirby

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Charles D. Kirby
6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) Feb. 11, 1895

8. AGE: Years	Months	Days	If less than one day
50	9	14	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Home Duties
11. Industry or business

FATHER
12. Name John Rehmert
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace Baltimore, Md.

16 (a) Informant Charles D. Kirby
(b) Address 1307 W. Pratt St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 30, 1945 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director Frederick A. Cole
(b) Address 1200 W. Lombard St.

NOV 29 1945 (b) Huntington Williams, M.D.
(Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 26 1945, at 2:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1941 to Nov. 26 1945, and that I last saw h[illegible] alive on Nov. 26 1945

Immediate cause of death	Duration
Congestive Pneumonia	11/30/45
Due to Rheumatic Cardiac Insufficiency	?
Due to	
Other Condition Pernicious Fibrillation Arteriosclerosis	?

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury —

23. Signature Carl P. Rosting M. D.
Address 312 W. Lombard St. Date signed 11/29/45

634583

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

74a

Registered No. 634583

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madeira & Linden
(c) Hospital or institution:
Maryland Gen. Hosp. V
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 332 N. Hilton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EDNA IRENE HOOPER MAGEE

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: John S. Magee

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 15, 1898

8. AGE: Years	Months	Days	If less than one day
47	3	13	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Maurice R. Hooper
13. Birthplace Baltimore

MOTHER
14. Maiden Name Catherine Luckhardt
15. Birthplace Baltimore

16 (a) Informant Mr. John S. Magee
(b) Address 332 N. Hilton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/1/45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

NOV 29 1945 (Date rec'd by registrar)

(b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 28 1945, at 9:55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-7 1945 to 11-27 1945 and that I last saw h-r alive on 11-28 1945.

Immediate cause of death: Lymphatic leukemia — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. M. Gandil M. D.

Address Maryland General Hospital Date signed 11-27-45

X

634584

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

634584 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3040 Arunah Ave.
(c) Hospital or institution:
16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3040 Arunah Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SARAH ELLEN COX

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife: William H.Cox
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Feb. 9, 1860

8. AGE: Years	Months	Days	If less than one day
85	9	18	hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: none
11. Industry or business

FATHER
12. Name: Charles Baltzell
13. Birthplace: Md.

MOTHER
14. Maiden Name: Mary F. Miller
15. Birthplace: Md.

16 (a) Informant: Mr. Raymond E. Burnett
(b) Address: 3040 Arunah Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/29/45 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 NOV 29 1945 (Date received by registrar) (b) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27, 1945, at 9:00A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 25 1945 to Nov 27 1945 and that I last saw h alive on Nov 26 1945

Immediate cause of death	Duration
Cardiac Asthma.	6h.
Due to Cardio Vascular dis.	5 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: E M Tom M. D.
Address 1202 St Paul St Date signed 11/28/45

VS 150

X

G34585

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G34585 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Dundalk (If outside city or town limits, write RURAL and give town)
(d) Street No. 2406 Keyway (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME David Eckert

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 212-01-5142

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Margaret Eckert

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 7, 1886

8. AGE: Years 59 | Months 6 | Days 20 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Cooper

11. Industry or business Kimball - Tyler Co.

FATHER
12. Name John F. Eckert
13. Birthplace Balto.

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Rev. Fred'k. J. Eckert
(b) Address 2608 Garrison Blvd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/1/45 (month) (day) (year)
(c) Cemetery or crematory Oaklawn Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 NOV 29 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar.

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/27 1945; at 6:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/11 1945 to 11/27 1945 and that I last saw him alive on 11/27 1945

Immediate cause of death	Duration
Coronary Thrombosis	
Due to Arteriosclerotic C.V. Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(c) Means of injury

23. Signature Martin F. Strobel M. D.
Address Md. Gen'l. Hospital Date signed 11/29/45

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34586

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

634586
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Towson
(If outside city or town limits, write RURAL and give town)
(d) Street No. 300 W. Pennsylvania Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Peart Cummings

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Charlotte Fossett Cumming
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 9, 1883

8. AGE: Years	Months	Days	If less than one day
62	7	19	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Hershey S. Cumming
13. Birthplace Carroll Co., Md.

MOTHER
14. Maiden Name Mary V. Pearce
15. Birthplace Carroll Co., Md.

16 (a) Informant Mrs. Charlotte F. Cumming
(b) Address 300 W. Pennsylvania Ave., Towson

17 (a) Burial (b) Date thereof 12/1/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. James Cem.
Location My Lady's Manor

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 NOV 29 1945 (b) Huntington Williams M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/28 1945 at 6:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/27 1945 to 11/28 1945 that I last saw him alive on 11/28 1945

Immediate cause of death	Duration
gangrene of leg	
Due to generalized arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Roy H. Orr, Jr. M. D.
Address 1815 Hoye-Bute Date signed 11/29/45

634587

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94 Q

634587 Registered No.

Please write plainly with ink or indelible pencil. Do not use abbreviations. If the exact information is not known, supply approximate dates, if any. Answer all questions. Underlining is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: McCulloh & Eager St.
(c) Hospital or institution: Engine House #25

(d) Length of stay in hospital or inst. (yrs., mos., or days): V
(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County:
(c) City or town: Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 5910 Bertram Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country:

3 (a) FULL NAME George Klein

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife: Mary Elizabeth Klein
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): April 11, 1884

8. AGE: Years	Months	Days	If less than one day
61	7	16	hr. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)
10. Usual Occupation: Fireman
11. Industry or business: Baltimore City

FATHER
12. Name: John Klein
13. Birthplace: Germany

MOTHER
14. Maiden Name: Unknown
15. Birthplace: "

16 (a) Informant: Mrs. Elizabeth Klein
(b) Address: 5910 Bertram Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/30/45 (month) (day) (year)
(c) Cemetery or crematory: Baltimore Cem.
Location: Baltimore, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) NOV 29 1945 (b) Huntington Ave. Baltimore, Md.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27 1945, at 11 30 A M

21. I certify that I took charge of the remains described above, held an Autopsy + Insp thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Lis death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary Disease

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury: at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury:

23. Signature: Howard J. Mallonee M.D.
Medical Examiner.
Date signed 11-27-45

634,588

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

634,588 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2222 Druid Hill Ave
(c) Hospital or institution: 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2222 Druid Hill Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anthony Cheney

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Edna Mae.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 28, 1893

8. AGE: Years 52 | Months 10 | Days 29 | If less than one day hr. min.

9. Birthplace Panama Canal Zone
(Town, county, and state)

10. Usual Occupation Electrician

11. Industry or business

FATHER
12. Name Charles Cheney
13. Birthplace Panama Canal Zone

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Edna Mae Cheney
(b) Address 2222 Druid Hill Ave

17 (a) Burial (b) Date thereof Nov 29 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore Md.

18 (a) Funeral director The Geo. M. Shaw Co.
(b) Address 1411 Druid Hill Ave

NOV 29 1945 Huntington Williams M.D.
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 27 1945 3:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 27 1945 to Nov 27 1945 and that I last saw h alive on 19

Immediate cause of death: Cerebral Hemorrhage — Duration 3 hrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address Date signed 11/29/45

VS 150

634589

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 E

Registered No. 634589

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2808 Echodale Ave.
(c) Hospital or institution: V T
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2808 Echodale Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Annie F. Wallace

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Thompson F.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 5-1874

8. AGE: Years 71 | Months 9 | Days 23 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Stay Home

11. Industry or business

FATHER
12. Name James C. Causey
13. Birthplace Md.

MOTHER
14. Maiden Name Esther A. Todrus
15. Birthplace Md.

16 (a) Informant Mrs. Marie Hoffman
(b) Address 2808 Echodale Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11- -45 (month) (day) (year)
(c) Cemetery or crematory Moreland
Location Baltimore

18 (a) Funeral director Leopold J. Ruck
(b) Address 5305 Harford Rd.

19 (a) (Date rec'd by registrar) (b) Washington, D.C.

NOV 29 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 28 - 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 4 1945 to Nov 28 1945, and that I last saw h alive on Nov 27 1945.

Immediate cause of death: Myocarditis — Duration Nov 14

Due to: Senile Dementia — Several year

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation: None

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: None at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature John A Evans M. D.

Address 612 N 40 St Date signed

634590

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 a

Registered No. 634590

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2019 Christian St
(c) Hospital or institution: No

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2019 Christian St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Gardner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Late Rochelle
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct, 5, 1862

8. AGE: Years	Months	Days	If less than one day
83	1	1424	hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation
11. Industry or business Farmer

FATHER
12. Name Max Gardner
13. Birthplace Russia

MOTHER
14. Maiden Name Rachael ?
15. Birthplace Russia

16 (a) Informant William Henry Gardner
(b) Address 2019 Christian St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof NOv 30, 1945 (month) (day) (year)
(c) Cemetery or crematory Work Men Circle Cem
Location German Hill Road

18 (a) Funeral director Sol Lrvinson & Bros
(b) Address 1124-1126 W North Ave

NOV 29 1945 (b) Huntington Williams, MD
(Date received by local registrar) Registrar

VS 150

MEDICAL CERTIFICATION 6.15

20. DATE OF DEATH November 29 1945, at A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 15 1945 to Nov 29 1945 and that I last saw him alive on Nov 29 1945

Immediate cause of death	Duration
Pneumonia due to carcinoma of Esophagus	9 mos.
Due to	
Due to	
Other Conditions Arteriosclerosis + arteriosclerotic Heart disease (Include pregnancy within 3 months of death)	

Date of operation July 20, 1945 (approx)
Major findings of operation: Carcinoma of esophagus with metastases
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry D. Sherwood M.D.
M. D.
Address 1322 Eutaw Pl Date signed Nov 29 45

634591

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No. 634591

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 939 W Lexington St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 46

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 939 W Lexington St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Lawrence Jones

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race C | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Rosie Jones.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1899

8. AGE: Years 46 | Months 8 | Days | If less than one day hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation Hammock
11. Industry or business

FATHER
12. Name William Scott
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Annie Mc Roy
15. Birthplace Baltimore Md.

16 (a) Informant Annie Mace Anderson
(b) Address 1519 W. Saratoga St.

17 (a) Burial (b) Date thereof Nov. 30 45.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R Williams
(b) Address 322 N. Schroeder St

19 (a) (b) Huntington Williams, M.D.
Registrar

NOV 29 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-26-1945 at 4:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-1-1945, to 11-26-1945, and that I last saw h[illegible] alive on 11-25-1945.

Immediate cause of death	Duration
(a) Cerebral Vascular Renal Disease	1 year
Due to (b) Hypertensive	
Due to (c)	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address [illegible] Date signed 11/28/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634592

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

634592 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 507 S. Lakewood Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 507 S. Lakewood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William S. Literski

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years	Months	Days	If less than one day
58			hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Anotony Literski
13. Birthplace Poland.

MOTHER
14. Maiden Name Rose Brzuchowska
15. Birthplace Poland

16 (a) Informant Martha Literski
(b) Address 507 S. Lakewood

17 (a) Burial (b) Date thereof 11-30-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Balto. City

18 (a) Funeral director Wm. L. Fialkowski
(b) Address 2007 Eastern Ave

19 (a) (Date received) NOV 29 1945 (b) Registrar for Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 27, 1945 at 9 45 A.M.

21. I certify that I took charge of the remains described above, held an Inquiry & Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mencis M.D.
Medical Examiner.
Date signed 11-27-45

634.93

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93D

634.93
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greenspring & Belvedere Aves
(c) Hospital or institution: Levindale Hebrew Home + Infirmary
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. Greenspring & Belvedere (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martha Koslinsky

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1859

8. AGE: Years	Months	Days	If less than one day
86			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Hospt Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-29-45 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location Lehman Hall Md.

18 (a) Funeral director Jacob Levy Inc
(b) Address 1439 E. Balto St.

19 (a) (Date rec'd by registrar) (b) Wilmington M.F.

VS NOV 29 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27 1945, at 1.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-29 1942 to 11-27 1945 and that I last saw h alive on 11-27 1945.

Immediate cause of death: Cer. card. vascular disease. Hyper Tension — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H Edmund Levin M.D.
Address Levindale Date signed 12/1/45

X

634594 BALTIMORE CITY HEALTH DEPARTMENT 634594
CERTIFICATE OF DEATH 50 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 59 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1223 Linden Ave. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. [redacted] (Elizabeth Jennison) Wyckoff

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Mr. Ernest Wycoff
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 6 1886

8. AGE: Years	Months	Days	If less than one day
59 99	8 9	22	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name Mr. Rev. Joseph Jennison.
13. Birthplace Louisiana.

MOTHER
14. Maiden Name Elizabeth ?
15. Birthplace ?

16 (a) Informant (Husband) Mr Ernest Wycoff
(b) Address 1223 Linden Ave., City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 30/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3601 Frederick Ave

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 1100 Eutaw Place

19 (a) NOV 29 1945 (Date received by Registrar) Huntington Hilliard, M.D. (Signature of Registrar)

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 28 1945, at 1:55 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 12, 1945 to Nov. 28 1945 and that I last saw h&R alive on Nov. 28 1945

Immediate cause of death: Carcinomatosis — Duration

Due to Carcinoma of Breast

Due to

Other Conditions Arteriosclerotic Cardio-Vascular Disease
(Include pregnancy within 3 months of death)

Date of operation March 1942

Major findings of operation: Carcinoma of Breast.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Crawford M. Kilpatrick, Jr. M. D.
Address Union Memorial Hosp. Date signed 11-28-45

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34595

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

49E

G34595 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden & Madison Ave
(c) Hospital or institution: Md. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr 11 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2815 Parkwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Amelia C. Erdman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Henry Erdman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 25. 1871

8. AGE: Years 74 | Months 7 | Days 2 | If less than one day hr. min.

9. Birthplace Balto, Md (Town, county, and State)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name ~~Amelia C. Erdman~~ A. Fritschett
13. Birthplace Germany

MOTHER 14. Maiden Name Babetta Wenzinger
15. Birthplace Germany

16 (a) Informant Lillian A. Cochran
(b) Address 2815 Parkwood ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 29/1945 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cemetery
Location Franklin Road

18 (a) Funeral director John O Mitchell Sons
(b) Address 19 E Eutaw Place

19 (a) Date received by registrar NOV 30 1945 (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/27 1945 4:35 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/2 6 1945 to 11/27 1945 and that I last saw h. alive on 11/27 1945.

Immediate cause of death Malegnant Tumor, extensively spread in both

Due to parametria, adnexa, & pelvic cavity causing

Due to pressure upon sigmoid, ureters &

Other Conditions ureters.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dudley Phelps M.D.
Address Md. Gen. Hosp. Date signed 11/29/45

G34596

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

164a

Registered No. G34596

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 D.
(e) Length of stay in Baltimore (yrs., mos., or days) 46 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 12 N. Loudale st.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry C. Edwards

3 (b) If veteran, name war

3 (c) Social Security Account 216-32-862

4. Sex: male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: M Garfield

6 (b) Name of ~~husband~~ or wife: Mildred

6 (c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) Feb 26 1899

8. AGE: Years 46 | Months 9 | Days 2 | If less than one day ... hr. ... min.

9. Birthplace Balto Md.

10. Usual Occupation Power Stor Repairman

11. Industry or business Western Electric

FATHER 12. Name Henry Edwards

FATHER 13. Birthplace Balto Md.

MOTHER 14. Maiden Name May Hampson

MOTHER 15. Birthplace Balto Md.

16 (a) Informant Mrs M. Edwards

(b) Address 12 Rosedale St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/1/45 (day) (year)

(c) Cemetery or crematory Loudon Pk

Location Fred Gol.

18 (a) Funeral director Geo. H. Leyenbach

(b) Address 1-N-N Lyndhurst St

19 (c) NOV 29 1945 Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 28th 1945, at 3 50 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy / Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation due to hanging.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-28-45 at 3:45 A. M.
(b) Where did injury occur? Southwestern Police Station
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Hanged self to door with necktie

23. Signature Howard R. Mebane M.D.
Medical Examiner.
Date signed 11-28-45

G34597

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 842

G34597 Registered No.

write the causes of death clearly and legibly. Physicians: please write the correct age is especially important. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Md.
(c) Hospital or institution: John Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D. O. A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 807 N. Glover Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Weitzel Jr

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 24 1942

8. AGE: Years 3 | Months 1 | Days 4 | If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER 12. Name William Weitzel
13. Birthplace Balto

MOTHER 14. Maiden Name Catherine Nuetzel
15. Birthplace Baltimore

16 (a) Informant Wm Weitzel
(b) Address 807 N Glover St

17 (a) Burial (b) Date thereof Dec 1-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem
Location Catty

18 (a) Funeral director Lellis Funeral Home
(b) Address 2108 Orleans St

19 NOV 29 1945 (b) Huntington for Addison
(Date received by Local Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 28, 45 19 , at 11:10 A. M

21. I certify that I took charge of the remains described above, held an Inspection & Inquest thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Familial Pancreatic Fibrosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madison M.D.
Medical Examiner.
Date signed November 28, 1945.

Schaub

634598

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1795

Registered No. 634598

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2635 Greenmount Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 d
(e) Length of stay in Baltimore (yrs., mos., or days) 24 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2635 Greenmount Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary L. Schaub

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Amos H. Schaub
6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) Oct 2-1897

8. AGE: Years	Months	Days	If less than one day
48	1	26	hr. min.

9. Birthplace Washington DC
(Town, county, and state)
10. Usual Occupation
11. Industry or business At Home

FATHER
12. Name Francis Redmond
13. Birthplace Md

MOTHER
14. Maiden Name Dont know
15. Birthplace Balto

16 (a) Informant Amos L. Schaub
(b) Address 2638 Greenmount

17 (a) Burial (b) Date thereof Dec 1-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem
Location Rural

18 (a) Funeral director Uellrich Funeral Home
(b) Address 2008 Orleans

19 (a) NOV 29 1945 (b) Huntington Mills Registrar, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 28 - 1945, at 8 30 A.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute barbiturate poisoning (Barbital)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Nov. 27 1945 ? M.
(b) Where did injury occur? 2635 Greenmount Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Ingestion of Barbital

23. Signature Robert L. Graham M.D.
Medical Examiner.
Date signed Nov. 28 1945

VS 151

X

Please answer all questions. Physicians: please write the causes of death clearly and legibly.

G34599

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G34599

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1618 Rutland Ave
(c) Hospital or institution: of
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1618 Rutland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Sewell

3 (b) If veteran, name war —

3 (c) Social Security Account No. 215-03-3694

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mary B Sewell

6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) May 10 - 1891

8. AGE: Years	Months	Days	If less than one day
54	6	17	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Mac Tenant

11. Industry or business

FATHER
12. Name John L Sewell
13. Birthplace England

MOTHER
14. Maiden Name Susana Bell
15. Birthplace England

16 (a) Informant Mary B Sewell
(b) Address 1618 Rutland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location City

18 (a) Funeral director Wellzit Funeral Home
(b) Address 2008 Orleans St

19 NOV 29 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Address

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 27 1945 at 10 50 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 10 1945 to Nov 27 1945, and that I last saw h 17 alive on Nov. 27 1945.

Immediate cause of death	Duration
Acute Coronae Failure	1 day
Due to Chronic Myocardial Degeneration	4 yrs +
Due to Bronchopneumonia	10 hrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature David Schneider M. D.
Address 110 N. Oil, also Mrs Date signed 11-27-45

X Schneider

634600

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 634600

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6016 Sefton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6016 Sefton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William H. Watchman

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Mary Watchman
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) June 10 1872

8. AGE: Years	Months	Days	If less than one day
73	5	17	..... hr. ..... min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Guard
11. Industry or business Chemical Co

FATHER
12. Name W. C. Watchman
13. Birthplace England

MOTHER
14. Maiden Name Carolina DeLong
15. Birthplace Baltimore

16 (a) Informant Mary Watchman
(b) Address 6016 Sefton Ave

17 (a) Burial (b) Date thereof Nov 30 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Reisters St

19 (a) NOV 29 1945 Huntington Millemann M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 27th 1945, at 11a M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1945 to Nov 27 1945, and that I last saw him alive on 11/27 1945.

Immediate cause of death	Duration
Cardiac failure	2d.
Due to Hypertensive arteriosclerotic CVD.	1yr.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. A. Gold M.D.
Address 6100 Hanford Rd Date signed 11/29/45

VS 150

634601

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 634601

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Balto, Md
(c) Hospital or institution:
Church Home & Infirmary
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Sparrows Point
(If outside city or town limits write RURAL and give town)
(d) Street No. 1008 H St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Morgan

3 (b) If veteran, name war: World I

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Florence Morgan

6 (c) If alive, give age: 48 years

7. Birth date of deceased (mo., day, yr.) June 6, 1892

8. AGE: Years	Months	Days	If less than one day
53	5	20	hr. min.

9. Birthplace: Baltimore
(Town, county, and state)

10. Usual Occupation: Garage Business

11. Industry or business

FATHER
12. Name: Edw Morgan
13. Birthplace: Baltimore

MOTHER
14. Maiden Name: Louise Heck
15. Birthplace: Baltimore

16 (a) Informant: Mrs Florence Morgan
(b) Address: 1008 H St Sparrows Pt

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 30th (month) (day) (year)
(c) Cemetery or crematory: Oak Lawn Cem
Location: City

18 (a) Funeral director: Ulrich Funeral Home
(b) Address: 2008 Orleans St

19 (a) NOV 29 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 26 1945, at M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary Occlusion

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury:

23. Signature: Roland C. Fratcher M.D.
Medical Examiner.
Date signed 11-26-45

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634602

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1700

Registered No. 634602

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 940 Brookes Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Samuel da Lavier

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) ~~Single~~, married, ~~widowed~~, or ~~divorced~~: Married

6 (b) Name of husband or wife: Bessie Dalavier

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 16 1863

8. AGE: Years 82 | Months 3 | Days 13 | If less than one day ..... hr. ..... min.

9. Birthplace France (Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs Harry O Levin
(b) Address 940 Brookes Lane

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 11/30/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto Md

18 (a) Funeral director David Lord Regis Sons
(b) Address 1902 Eutaw Place

19 (a) NOV 29 1945 Huntington Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 29, 1945, at 5 37 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Hes death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Occlusion
Generalized arteriosclerosis

Due to

Other Conditions Chronic Vascular hypertension
Multiple contusions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☑ cause of death, fill in the following:
(a) Date of injury 11-21-45 at 5 P. 13/1 M.
(b) Where did injury occur? Eutaw Place & Brookes Lane
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
Means of injury Pedestrian struck by auto

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 11-29-45

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34603 — Dr Schoenfeld 2301 Annapolis Rd — G34603

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2324 Annapolis Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 2324 Annapolis Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bernard A Thompson

3 (b) If veteran, name war: N
3 (c) Social Security Account No.: None

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Elizabeth
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): March 25, 1856

8. AGE: Years 89 | Months 8 | Days 3 | If less than one day: hr. min.

9. Birthplace: London Co Va
(Town, county, and state)

10. Usual Occupation: Retired
11. Industry or business:

FATHER
12. Name: John F Thompson
13. Birthplace: London Co Va

MOTHER
14. Maiden Name: Lucinda Kidwell
15. Birthplace: Va

16 (a) Informant: Clara Leah Myers
(b) Address: 2324 Annapolis Road

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11/30/45 (month) (day) (year)
(c) Cemetery or crematory: Chestnut Grove
Location: Hyattsville Md

18 (a) Funeral director: Gilhooly Funeral Service
(b) Address: 1219 E Fort Ave

19 NOV 29 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 28 1945, at 4:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 20 1945, to Nov 28 1945, and that I last saw h[illegible] alive on Nov 27, 1945.

Immediate cause of death	Duration
Cerebral Hemmorhage	4 days
Due to Arteriosclerosis -	10 year
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: [signature]
Address: 2301 Annapolis Rd Date signed 11/29/45

VS 150

2301 X Schoenfeld

REMARKS MADE HEREIN, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634604

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. 634604

PRINT WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 906 Little Pine
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 906 Little Pine (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Mary Porter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-1-1895

8. AGE: Years	Months	Days	If less than one day
50	1	26	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Will Hughes
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Ford
15. Birthplace Balto. Md.

16 (a) Informant Alma Bozer
(b) Address 309 Otterbine St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-1-1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Alburn Cemetery
Location Md.

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

NOV 29 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27, 1945, at 5 A 00 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-25-1945 to 11-27-1945, and that I last saw h[illegible] alive on 11-27-1945.

Immediate cause of death — Duration

Cerebral Hemorrhage — 2-days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M.D.

Address 745 N. Gay Date signed 11-28

Interim for Williams, M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634605

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46a

634605 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2726 E Chase St
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2726 E Chase St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Paul P Menski

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-05-4286

4. Sex: Male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Constance

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years 64 | Months | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Moulder

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mary Allen
(b) Address 618 E Lehigh St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/1/45 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem.
Location Germantown Hill Rd.

18 (a) Funeral director John J. Duda
(b) Address 2829 Hudson St

19 (a) (Date rec'd by registrar) NOV 29 1945 Huntington Williams, M.D. Registrar

VS

MEDICAL CERTIFICATION

20. DATE OF DEATH November 27, 1945 at 10:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from August 3, 1945 to Nov. 27, 1945 and that I last saw him alive on Nov. 27, 1945

Immediate cause of death	Duration
Carcinoma of the esophagus extending upward from the cardia	10 months
Due to Chronic emphysematous bronchitis	10 years
Due to Myocardial insufficiency	1 day
Other Conditions Arterio-sclerosis	?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury A. B. Monushas M.D.

23. Signature I. B. Bronushas, M. D.
Address 3037 O'Donnell St Date signed 11-28-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634606

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

634606 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2903 Hudson St
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Yr
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2903 Hudson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** S. Harry Sprole

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Anna A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 28 1871

8. AGE: Years: 74 | Months: 4 | Days: - | If less than one day: hr. min.

9. Birthplace: Baltimore Md. (Town, county, and state)

10. Usual Occupation: railroad engineer

11. Industry or business: Retired

FATHER
12. Name: Samuel Sprole
13. Birthplace: Baltimole

MOTHER
14. Maiden Name: Kate Tierney
15. Birthplace: Baltimore

16 (a) Informant: Harry J. Sprole
(b) Address: 2932 Hudson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/1/45 (month) (day), (year)
(c) Cemetery or crematory: New Cathedral
Location: Edmondson Ave

18 (a) Funeral director: John J. Duda
(b) Address: 2629 Hudson St.

19 (a) NOV 29 1945 (Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 28 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 23 1945, to Nov. 28 1945, and that I last saw him alive on Nov. 28 1945.

Immediate cause of death: Uremia — Duration:

Due to: Hypertrophy of Prostate

Due to: Arteriosclerosis Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph Toohey

Address 441 S. Edmondson Ave Date signed 11/29/45

Huntington Williams, M.D.

G34607

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170c

Registered No. G34607

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Lauil Baltimore Hosp. 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2703 Annapolis Blvd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eugene Vernon Gerlach

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov. 24, 1932

8. AGE: Years	Months	Days	If less than one day
13		3	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation School-child
11. Industry or business

FATHER
12. Name Charles P. Gerlach
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mabel Fitch
15. Birthplace Baltimore, Md.

16 (a) Informant Charles P. Gerlach
(b) Address 2703 Annapolis Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/30/45 (month) (day) (year)
(c) Cemetery or crematory St. Mathew's
Location O'Donnell St.

18 (a) Funeral director M. W. E. Dippel & Sons
(b) Address Broadway & Ann St.

NOV 29 1945 (Date rec'd by Registrar) Washington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27th 1945, at 6:10 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Skull fracture
Intracranial hemorrhage.
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11/27/45 at a.a. 5:45 P.M.
(b) Where did injury occur? Annapolis Blvd + Church
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? —
(d) Means of injury Pedestrian struck by auto.
23. Signature Benedict Skitarelic M.D.
Medical Examiner.
Date signed 11-28-45

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634608

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

634605 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1445 Hull St.
(c) Hospital or institution:
2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 54 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1445 Hull St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Arnold Schmick.

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-07-7076

4. Sex Male. 5. Color or race White 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Appelonia Schmick

6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) April 8, 1891

8. AGE: Years 54 Months 7 Days 17 If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business

FATHER 12. Name John Schmick.

13. Birthplace Balto.

MOTHER 14. Maiden Name Hattie Laeffler.

15. Birthplace Germany

16 (a) Informant Mrs. Appelonia Schmick

(b) Address 1445 Hull St.

17 (a) Burial (b) Date thereof 11/30/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Cross Cem

Location Annapolis Blvd.

18 (a) Funeral director Chas. F. Dill.

(b) Address 1321 E. Fort Ave.

19 (a) NOV 29 1945 (b) Registrar Williams M.D.
(Date received by registrar)

Hunting for

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 25 1945, at 11 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 25 1945 to Nov. 25 1945; and that I last saw h alive on Nov. 24 1945.

Immediate cause of death Carcinoma Pancreas — Duration 3 mo

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Oct. 15 th

Major findings of operation: Ca. Pancreas

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature O F A Stevens M. D.

Address 816 Harford Rd Date signed 11 26 45

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Lentz Fourth Sunday after Easter Place La 6660 La 2255 Before 10 a.m.

634609

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

634609 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 614 Lennox st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 614 Lennox st.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Ann Dunn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or ~~divorced~~
Female	White	Widowed

6 (b) Name of husband ~~or wife~~ John F. Dunn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 14th 1864

8. AGE: Years	Months	Days	If less than one day
about 81	9	14	hr. min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business Self

FATHER
12. Name ? McGlenn
13. Birthplace

MOTHER
14. Maiden Name Catherine Fullerton
15. Birthplace

16 (a) Informant Mrs Cecil Dunn
(b) Address 1429 Mt. Royal Ave

17 (a) Burial (b) Date thereof 11/30/45
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul st.

19 (a) Huntington Williams Registrar
(Date rec'd by registrar)

NOV 29 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 28 1945 at 11 30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 25 1945 to Nov 28 1945 and that I last saw h e alive on Nov 27 1945

Immediate cause of death	Duration
Cerebral hemorrhage	3 days.
Due to	
Due to Arteria-sclerosis	2 years
Other Conditions.	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Frederick Lentz M.D.
Address Temple Garden Apts Date signed 11-29-45

X

G34610

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

122a

Registered No. G34610

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution:
Monument & Rutland Ave
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13-4
(e) Length of stay in Baltimore (yrs., mos., or days) 46 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3510 Woodbrook Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Kandel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Sarah
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years	Months	Days	If less than one day
67			hr. min.

9. Birthplace Austria
(Town, county, and state)

10. Usual Occupation

11. Industry or business Retired

FATHER
12. Name Harry Kandel
13. Birthplace Austria

MOTHER
14. Maiden Name Esther Meyers
15. Birthplace Austria

16 (a) Informant Philip Kandel
(b) Address 3510 Woodbrook Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 30, 1945 (month) (day) (year)
(c) Cemetery or crematory Shaarei Tefiloh Cemetery
Location Windsor Mill Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) Nov 30 1945 (Date received by Registrar) (b) Registrar's No. 6 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-28 19 45 at 3 00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-26 19 45 to 11-28 19 45
and that I last saw h[illegible] alive on 11-28 19 45

Immediate cause of death	Generalized peritonitis	Duration
Due to	Ruptured G Bowel	
Due to	Duodenal ulcer ruptured	
Other Conditions		

(Include pregnancy within 3 months of death)
Date of operation 11-27-45
Major findings of operation: Generalized peritonitis
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature John L Rosenthal M. D.
Address Sinai Hospital Date signed 11-28-45

X

G34611

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

G34611 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 505 S. BOND ST.
(c) Hospital or institution: 2-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 15 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 505 S. BOND ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HAZEL IRENE MARCH

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NONE

4. Sex: FEMALE
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: WIDOW

6 (b) Name of husband or wife: HENRY E. MARCH
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): MAR. 1 1892

8. AGE: Years: 53 | Months: 8 | Days: 28 | If less than one day: hr. min.

9. Birthplace: VIRGINIA (Town, county, and state)
10. Usual Occupation: HOUSE WIFE
11. Industry or business: AT HOME

FATHER
12. Name: FATHER WILLIAM GODSEY
13. Birthplace: VIRGINIA

MOTHER
14. Maiden Name: CORA F. HARRIS
15. Birthplace: VIRGINIA

16 (a) Informant: CORA F. HARRIS (MOTHER)
(b) Address: 505 S. BOND ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof DEC. 2/45 (month) (day) (year)
(c) Cemetery or crematory: GODSEY CEM.
Location: PETERSBURG VIRGINIA

18 (a) Funeral director: Leilly & Zeiler inc.
(b) Address: 403 S. WOLFE ST.

19 (a) NOV 30 1945 (Date received by Registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: NOV. 29 1945, at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1945 to Nov 5 1945 and that I last saw h[er] alive on Nov 5 1945.

	Duration
Immediate cause of death: Lobar Staph. Pneumonia	11/22/45
Due to: Arthritis of Liver	8/1945
Due to: Chr. Nephritis	8/1945
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: William J. Reamer M. D.
Address: 501 Keswick Date signed: 11/29/45

x Reamer

634612

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

Registered No. 634612

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1804 Barclay St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1804 Barclay St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ethel A Nitters

3 (b) If veteran, name war: W
3 (c) Social Security Account No. 212-05-7893

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Sngl

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 7. 1877

8. AGE: Years 68 | Months 8 | Days 21 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Seamstress

11. Industry or business

FATHER
12. Name Thomas S Nitters
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Charlotte Nicol
15. Birthplace Baltimore Md

16 (a) Informant Lotta Nitters
(b) Address 1804 Barclay St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 30 45 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Baltimore Md

18 (a) Funeral director Thilhorn York Inc
(b) Address 219 E Fayette St

NOV 30 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 28 1945, at 6 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 26 1945 to Nov 28 1945, and that I last saw h-er alive on Nov 28 1945

Immediate cause of death	Duration
Cachexia	
Due to Carcinoma of breast (left)	since Apr 26-45
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation Apr 28 - 45

Major findings of operation: Carcinoma of left breast & axillary metastasis

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George A Bowden

Address 517 E North Ave Date signed 11 29 45

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634613

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

183

Registered No. 634613

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Eden Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2010 Bank Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert Reese

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct 7, 1878

8. AGE: Years 67 | Months 1 | Days 21 | If less than one day: hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name John Reese
13. Birthplace Md

MOTHER
14. Maiden Name Catherine Rodenbough
15. Birthplace Balto Md

16 (a) Informant Mrs Carrie Bondell
(b) Address 2010 Bank St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/3/45 (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director William Cook Inc
(b) Address 2124 Pont St.

19 (a) NOV 30 1945 (Date rec'd by registrar) (b) Huntington Williams, Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 28, 1945, at 4:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Drowning.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury found 11-28-45 at 4:30 P.M. 2/3
(b) Where did injury occur? Foot of Washington St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public. While at work? No.
(d) Means of injury found drowned.

23. Signature Benedict Skotarelic M.D.
Medical Examiner.
Date signed November 29, 1945

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34614

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46a

G34614

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1285 WILLIAM ST

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 24

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County

(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)

(d) Street No. 1285 WILLIAM ST. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME JOSEPH. L. KOTMAIR

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of husband or wife BARBARA KOTMAIR

6 (c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) DEC 31 1865

8. AGE: Years	Months	Days	If less than one day
79	10	28	hr. min.

9. Birthplace BALTIMORE MD (Town, county, and state)

10. Usual Occupation LABORER

11. Industry or business —

FATHER

12. Name PHILIP KOTMAIR

13. Birthplace GERMANY

MOTHER

14. Maiden Name NOT KNOWN

15. Birthplace GERMANY.

16 (a) Informant BARBARA KOTMAIR

(b) Address 1285 WILLIAM ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof DEC 1-1945 (month) (day) (year)

(c) Cemetery or crematory HOLY CROSS-CEM

Location A.A.Co

18 (a) Funeral director Bernard C Hurley

(b) Address 121 E West St

19 (a) (Date received by Registrar) NOV 30 1945 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 28 1945 at 4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 10 1945 to Nov 28 1945 and that I last saw him alive on Nov 27 1945.

Immediate cause of death	Duration
Carcinoma of Oesophagus	2 mos
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide no

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Joseph Pekorny M. D.

Address 2200 E Madison St Date signed 11/29/45

634615

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

634615 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Josephs Hosp 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1017 Appleton St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** William J. Hild

3 (b) If veteran, name war —

3 (c) Social Security Account No. 213-05-9586

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	MARRIED

6 (b) Name of husband or wife Minnie J. Hild
6 (c) If alive, give age 7 years

7. Birth date of deceased (mo., day, yr.) Oct. 21 1880

8. AGE: Years	Months	Days	If less than one day
65	1	7	hr. min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation Despasher
11. Industry or business Balto Trans it. Co

FATHER
12. Name Not known
13. Birthplace Not known

MOTHER
14. Maiden Name Not known
15. Birthplace Not known

16 (a) Informant Minnie J. Hild
(b) Address 1017 Appleton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof DEC 1-45 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto Md

18 (a) Funeral director Mrs Chas A G Roberts
(b) Address 2327 Edmondson Ave

19 (a) NOV 3 0 1945 (Date received by registrar) Registrar

Huntington Pharmacy

MEDICAL CERTIFICATION

20. **DATE OF DEATH** 11-28 1945, at 7:54 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-27 1945, to 11-28 1945, and that I last saw h-- alive on 11-28 1945.

Immediate cause of death	Duration
Cerebral Vascular Accident	
Due to Hypertensive C.V.D.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature W. B. Robertson M. D.
Address St Josephs Hosp Date signed 11-28-45

VS 150

X

634616

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. 634616

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 Jefferson Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-4
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md., (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2025 Jefferson St., (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) **FULL NAME** FRANCES C. EMERY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or ~~wife~~ Edward Emery

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 21, 1883

8. AGE: Years 62 yrs. | Months 2 | Days 6 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Fuchs
13. Birthplace Unknown

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Frances Harrison
(b) Address 2025 Jefferson Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/1/45 (month) (day) (year)
(c) Cemetery or ~~crematory~~ XXXX Oak Lawn
Location Eastern Ave. Rd. Balto. Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

19 (a) NOV 30 1945 (Date received by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 27 1945, at 12 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1940, to Nov 27 1945, and that I last saw h~~im~~er alive on Nov 27 1945.

Immediate cause of death	Duration
Chronic Diabetes Mellitus	20 yrs.
Due to Chron. Cardio Renal Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frances J Ayd M. D.
Address 2005 E. Madison St Date signed 11/28/45

VS 150

G34617 WANCOWICZ ✓ G34617

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

Registered No.

Please write plainly, with unfading ink. Every item of information should be carefully supplied. The street age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 602 S. Linwood ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Wancowicz

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-09-3233

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Peter Wancowicz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-27-10

8. AGE: Years	Months	Days	If less than one day
35	4	3	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Henry Liegerman

FATHER
12. Name Peter Wancowicz
13. Birthplace Md.

MOTHER
14. Maiden Name Bessie Hennings
15. Birthplace Md.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-3-45 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Baltimore, Md.

18 (a) Funeral director George A. Weber
(b) Address 703 So. Linn street

19 (a) (Registrar) Huntington Williams M.D.

NOV 30 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 29 Nov 1945, at 8:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 24 Nov 1945 to 29 Nov 1945 and that I last saw h[illegible] alive on 29 Nov 1945

Immediate cause of death Carcinoma
Respiratory failure

Duration
over

Due to Carcinoma

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Julius Fogel M. D.
Address Johns Hopkins Hosp. Date signed 29 Nov 1945

X

634618

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 634618

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3109 Dudley Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3109 Dudley Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ANNIE EVA DOLBY

3 (b) If veteran, name war: No

3 (c) Social Security Account No.: None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Augustus R. Dolby

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Sept. 2, 1857

8. AGE: Years 88 | Months 2 | Days 24 | If less than one day hr. min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Augustus Reinheart
13. Birthplace: Salem Mass.

MOTHER
14. Maiden Name: Annie Seifert
15. Birthplace: Baltimore

16 (a) Informant: Mrs. George H. Gahm
(b) Address: 3109 Dudley Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 1945 (month) (day) (year)
(c) Cemetery or crematory: Greenmount Cem.
Location: Baltimore Md.

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: North Ave. & Broadway

19 (a) Filed NOV 30 1945 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 23. 1945 at 1.15 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 16 1945 to Nov 26 1945 and that I last saw h[illegible] alive on Nov 25 1945

Immediate cause of death: Chronic Myocarditis — Duration

Due to: Senility

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Adam A. Todd M. D.

Address 1126 Dulaney Pl. Date signed Nov 27/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

631619

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. 631619

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4707 Roland Avenue
(c) Hospital or institution: 27-14
(d) Length of stay in hospital or inst. (yrs., mos., or days) ----
(e) Length of stay in Baltimore (yrs., mos., or days) 72 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County --------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4707 Roland Avenue
(If rural give location)
(e) Citizen of foreign country? ------ (Yes or No)
If yes, name country ------

3 (a) FULL NAME: Blanche W. McP. Steed

3 (b) If veteran, name war:

3 (c) Social Security Account No.:

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Frederick B. Steed

6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) Dec. 26, 1872

8. AGE: Years 72 | Months 11 | Days 2 | If less than one day -- hr. -- min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation: None

11. Industry or business: ------

FATHER
12. Name: Joseph Wright
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Not obtainable
15. Birthplace: Baltimore, Md.

16 (a) Informant: Theodore Requardt
(b) Address: 4707 Roland Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/30/45 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: Baltimore, Md.

18 (a) Funeral director: H. W. Mears and Son
(b) Address: 805 N. Calvert Street

19. NOV 30 1945 (Date received by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 28 1945, at 3.10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-1- 1945, to 11-28- 1945, and that I last saw h alive on 11-28 1945.

Immediate cause of death: Acute Cardiac Congestion — Duration: 2 days
Due to: Arterio Sclerosis —
Due to: Hypertension —
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Howard F. Warren M. D.
Address 2607 Garrison Blvd Date signed 11-28-45

VS 150

634620

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. 634620

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1223 W Baltimore St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. #1223 W. Baltimore St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mattie Kelly

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex female | 5. Color or race white | 6 (a) Single, married, widowed, or divorced. widow

6 (b) Name of husband or wife late Robert S.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 6th 1872

8. AGE: Years 73. | Months 2 | Days 22 | If less than one day hr. min.

9. Birthplace West, Va
(Town, county, and state)

10. Usual Occupation house work

11. Industry or business at home

FATHER
12. Name John House
13. Birthplace West, Va

MOTHER
14. Maiden Name Unknown
15. Birthplace West Va

16 (a) Informant Mrs Sadie E. Kemp
(b) Address 1112 N Montford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/1/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem
Location 4300 Old Frederick Road

18 (a) Funeral director John J Conway & Son
(b) Address 901-03 E Fayette St

19 (a) NOV 30 1945 (b) Huntington Mills Baltimore, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 28, 1945, at 4 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1942 to Nov 1945 and that I last saw h.. alive on Nov 26 1945.

Immediate cause of death Cerebral Hemorrhage due to Arterio-Sclerosis
Duration 3 yrs

Due to Renal Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D. P. Sutherland M.D. 5317 Park Heights Ave
Address 11/29/45 Date signed

correct age is especially important. Physicians: please write the

VS 3

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634661 634661

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1939 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3212 Garrison Blvd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME David Fink
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex M
5. Color or race wh
6 (a) Single, married, widowed, or divorced. M
6 (b) Name of husband or wife Annette
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 10/4
8. AGE: Years 41 Months Days If less than one day hr. min.
9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Pharmacist
11. Industry or business
FATHER 12. Name Benjamin
13. Birthplace Russia
MOTHER 14. Maiden Name Carrie
15. Birthplace Russia
16 (a) Informant Annette Fink
(b) Address 3212 Garrison Blvd
17 (a) Burial (b) Date thereof 11-30-45 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto Hebrew Cem
Location Alcan Road
18 (a) Funeral director Jacob Lewis Inc
(b) Address 1429 E Balto St
19 (a) NOV 30 1945 Registrar
(b) Registrar's signature Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-29- 1945, at 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-26 1945 to 11-29 1945 and that I last saw him alive on 11-29 1945.

Immediate cause of death Congestive Heart Failure & Chronic pulmonary fibrosis — Duration
Due to Coronary Sclerosis & Myocardial fibrosis
Due to Hypertension & Arteriosclerotic Heart disease
Other Conditions Rt Hydrothorax Bronchopneum; Pericarditis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Bertha Rader
Address Sinai Hosp Date signed M. D. 11/29/45

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634622

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

634622 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 13 N. Broadway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 13 N. Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Feldman

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Aron

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years 71 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Morris
13. Birthplace Russia

MOTHER
14. Maiden Name Soler
15. Birthplace Russia

16 (a) Informant Husband
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-30-45 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Pratt Rd + Hamilton Ave

18 (a) Funeral director Jacob Lewis Inc
(b) Address 1439 E. Balto St

19 (a) (Date received by registrar) NOV 30 1945 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 29 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1944 to Nov 29 1945, and that I last saw her alive on Nov 29 1945.

Immediate cause of death Acute heart failure — Duration 2½ hours

Due to Arterio sclerosis with Hypertension — 20 years

Due to Essential Hypertension — 8 yrs

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jacob Cohen M. D.

Address 1804 Eutaw Place Date signed 11/30/45

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634623

BALTIMORE CITY HEALTH DEPARTMENT X 97

CERTIFICATE OF DEATH

634623
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Green St
(c) Hospital or institution: Mercy Maryland University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore Carroll
(c) City or town Lutherville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Myra Leatherwood Myra H. Leatherwood

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife Edgar J. Leatherwood
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/4/1877

8. AGE: Years	Months	Days	If less than one day
68	-	25	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Henry Selby
13. Birthplace Md.

MOTHER
14. Maiden Name Emma Grimes
15. Birthplace Md

16 (a) Informant Myra J. Leatherwood
(b) Address Lutherville, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/3/45 (month) (day) (year)
(c) Cemetery or crematory Md Memorial
Location Baltimore, Md

18 (a) Funeral director F. J. WIPPERT & SON
(b) Address 510 Eastern Place

NOV 30 1945 (Date received by Registrar) (b) Livingston Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 29 1945, at 2:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 22 1945 to Nov 29 1945.
I last saw her alive on Nov 29 1945.

Immediate cause of death	Duration
Anoxia	
Due to Congestive Failure	
Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James R McClintock M.D.
M. D.
Address Univ. Hosp. Date signed 11/29/45

VS 150

X

G34624

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G34624 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2332 Edmondson Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2332 Edmondson Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME = Louis E. Cole =

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Ada L. Cole
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 20-1888

8. AGE: Years 57 | Months 6 | Days 8 | If less than one day — hr. — min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Salesman
11. Industry or business Retired

FATHER
12. Name Robert Cole
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth McCornelius
15. Birthplace Md

16 (a) Informant Ada L. Cole
(b) Address 2332 Edmondson Ave

17. Interment (b) Date thereof 12/1/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore, Md

18 (a) Funeral director J. D. Kappatzay
(b) Address 1300 Eutaw Place

19 (a) NOV 30 1945 (b)
(Date rec'd by registrar) Registrar of Vital Statistics

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/28/1945, at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 26 1941, to Nov 28 1945, and that I last saw h[im] alive on Nov 28 1945.

Immediate cause of death Coronary Thrombosis. — Duration 4 yrs
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert Glenn Hyn, M.D.
Address 2302 Edmondson Ave Date signed 11/29/45

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4835556 G34625

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 126

Registered No. G34625

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7+
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1037 N. Wolfe St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alice Louvinia.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	married

6 (b) Name of husband or wife Henry.
6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) 5-6-06

8. AGE: Years	Months	Days	If less than one day
39	5	21	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Nurse.
11. Industry or business

FATHER
12. Name Henry Mickey
13. Birthplace Va

MOTHER
14. Maiden Name Martha White
15. Birthplace Va

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 1, 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location A. A. County Md.
18 (a) Funeral director Mrs. Robert A. Elliott Dft
(b) Address 1129 N. Caroline St.
19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D.

VS NOV 30 1945

MEDICAL CERTIFICATION A

20. DATE OF DEATH Nov. 27 1945 at 1.25 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 12 1945 to Nov. 27 1945 and that I last saw h[illegible] alive on Nov. 27 1945.

Immediate cause of death: Hypertensive cardio vascular disease
Pulmonary congestion
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation 11-26-45
Major findings of operation: Myoma uteri. Cholelithiasis
of autopsy:

Duration
?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature J. Russell Jordan
Address 839 N. Broadway Date signed 11/27/45 M.D.

X

634626

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 B

634626 Registered No.

The entry of every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1300 N. Calvert St.
(c) Hospital or institution: 11
(d) Length of stay in hospital or inst. (yrs., mos., or days) ------
(e) Length of stay in Baltimore (yrs., mos., or days) 16 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County --------
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 929 N. Calvert St. (If rural give location) 7
(e) Citizen of foreign country? ------- (Yes or No)
If yes, name country -------

3 (a) **FULL NAME** Rondellet (Pauline Rendolet)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife ---------
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) ---------

8. AGE: Years	Months	Days	If less than one day
About 70	---	--	-- hr. -- min.

9. Birthplace Belgium (Town, county, and state)
10. Usual Occupation Child's Nurse
11. Industry or business ---------

FATHER 12. Name Not obtainable
13. Birthplace " " "

MOTHER 14. Maiden Name " " "
15. Birthplace " " "

16 (a) Informant S. R. Mears
(b) Address 805 N. Calvert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/1/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Meaks and Son
(b) Address 805 N. Calvert Street

19 (a) Nov 30 1945 (b) (Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 29th 1945, at 9:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 15th 1945, to Nov. 29th 1945, and that I last saw her alive on Nov 29th 1945.

Immediate cause of death	Duration
Coronary Occlusion	Abt
Mitral Stenosis	Long
Due to Aortic Stenosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Yes

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. L. Shotland M. D.
Address 926 N. Calvert St. Date signed Nov. 29/45

Accord. X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34627

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G34627 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 99 S. Collins Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 99 S. Collins Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** JOSEPH BONN REA

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary or May Rea
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 31, 1871

8. AGE: Years	Months	Days	If less than one day
74	7	27 28	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Retired foreman
11. Industry or business Baltimore City

FATHER
12. Name Joseph B. Rea
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Martha Arnold
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Mary Rea
(b) Address 99 S. Collins Ave.

17 (a) Burial (b) Date thereof 12/1/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (b)
(Date rec'd by Registrar)

NOV 30 1945 Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 28, 1945 at 10:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug, 5 1945 to Nov, 28 1945, and that I last saw him alive on Nov, 27 1945

Immediate cause of death Cerebral Hemorrhage "Stroke" ..... Duration 3 1/2mo
Due to Arterial Hypertension. Years
Due to
Other Conditions 0
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy NO

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: NO
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Lloyd Johnson M. D.
Address 610. Frederick Road Gatonsville, Md. Date signed Nov, 29, 1945

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634628

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

940

634628 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2835 W. North Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 75y.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2835 W. North Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** THEODORE BUCKINGHAM

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife: Margaret Buckingham
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 21, 1865

8. AGE: Years	Months	Days	If less than one day
80	3	7	hr. min.

9. Birthplace Westminster, Md. (Town, county, and state)
10. Usual Occupation Painter
11. Industry or business Retired 8 yrs.

FATHER
12. Name Alfred Buckingham
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah Snyder
15. Birthplace Md.

16 (a) Informant Mrs. Lillian Childs
(b) Address 2835 W. North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/1/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 160 NOV 30 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 28, 1945, at 6:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 15- 1945 to 11-28- 1945, and that I last saw h[illegible] alive on 11-28- 1945.

Immediate cause of death Angina Pectoris — Duration unknown
Due to Coronary Thrombosis — unknown
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chester Roland, M. D.
Address 2532 Edmondson Ave Date signed 11-29-45

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634629

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

634629 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5214 Beaufort Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5214 Beaufort Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME E. Allen Mayo.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: A. Pearl Anderson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 10, 1882

8. AGE: Years 63 | Months 8 | Days 19 | If less than one day hr. min.

9. Birthplace Ruhl. Balto. Co. Md.
(Town, county, and state)

10. Usual Occupation Salesman.

11. Industry or business Insurance

FATHER
12. Name William N. Mayo
13. Birthplace Balto. Co. Md.

MOTHER
14. Maiden Name Mary Frances Palmer
15. Birthplace Baltimore Co. Md.

16 (a) Informant Mrs. A. Pearl Mayo.
(b) Address 5214 Beaufort Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-1-45 (month) (day) (year)
(c) Cemetery or crematory London Park.
Location Baltimore Md.

18 (a) Funeral director Young Byrd & ...
(b) Address 5005 Park Heights Ave

19 (a) ... (Date rec'd by registrar) ... Registrar

NOV 30 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 29 1945, at 5 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 1 1944 to Nov 29 1945, and that I last saw him alive on Nov 29 1945

Immediate cause of death: Coronary Thrombosis — Duration 2 days
Due to: Arteriosclerosis — " "
Due to:
Other Conditions: Bronchial Pneumonia — 2 days
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul H Culm M. D.
Address 6116 Euclid St Date signed

VS 1

634630 BALTIMORE CITY HEALTH DEPARTMENT 634630
CERTIFICATE OF DEATH 38 E Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 629 W Lee St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) about 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 629 W Lee St
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Nellie Washington
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Widow
6 (b) Name of husband or wife Albert Washington
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) unknown
8. AGE: Years about 52 | Months | Days | If less than one day hr. min.
9. Birthplace Blackstone, Va (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER 12. Name Henry Ewen
13. Birthplace Va

MOTHER 14. Maiden Name Jenny Taylor
15. Birthplace Va

16 (a) Informant Hazel Washington
(b) Address 629 W Lee St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 1/45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Baltimore Md
18 (a) Funeral director Sarah L Brown Son
(b) Address 1080 W Montgomery St
19 (a) Nov 30 1945 (b) Registrar
Date received by registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 28 1945 at 1:45 AM
21. I certify that death occurred on the date above stated; that I attended deceased from Nov 27 1945 to Nov 28 1945 and that I last saw h e alive on Nov 28 1945

	Duration
Immediate cause of death Congestive Heart Failure	
Due to Arteriosclerosis	
Due to	
Other Conditions Hardening of Arteries	

(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature George McDonald M. D.
Address 644 N Carey St Date signed Nov 29 1945

G34631
JL - 97505

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47C

Registered No. G34631

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 8
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1831 N. Bond St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: William Kennard

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 7, 1885

8. AGE: Years 60 | Months 10 | Days 22 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George Kennard
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Barton
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 1-45 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Ave.

18 (a) Funeral director John A. Horan
(b) Address 3060 E. Baltimore St.

19 NOV 30 1945 (Date rec'd by reg.) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 29 1945, at 2.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 26 1945, to Nov. 29 1945, and that I last saw him alive on Nov. 29 1945.

Immediate cause of death	Duration
Metastatic Carcinoma of Lungs.	2
Due to Primary Site = Bronchogenic?	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Herbert K. Copeland Jr. M.D.
Address Balt. City Hosp. Date signed 11/29/45

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34632

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55D

G34632 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
U.S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 1 yr-3 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Michigan (b) County
(c) City or town Ontonagan
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Lauscher, George Alfred

3 (b) If veteran, name war

3 (c) Social Security Account No. 379-09-8628

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 8, 1887

8. AGE: Years	Months	Days	If less than one day
58	2	21	hr. min.

9. Birthplace Sturgeon Bay, Wisc.
(Town, county, and state)
10. Usual Occupation Engineer
11. Industry or business Seafarer

FATHER
12. Name Hubert Lauscher
13. Birthplace Sturgeon Bay, Wisc.

MOTHER
14. Maiden Name Mary Stoffel
15. Birthplace Kewanee, Wisc.

16 (a) Informant Records
(b) Address US Marine Hospital, Balto, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 30 45 (month) (day) (year)
(c) Cemetery or crematory Loudon Presbyterian
Location York Rd.
18 (a) Funeral director Colgan Funeral Home Inc
(b) Address 11644 York Rd
19 (a) (Signature of registrar) (b) Registrar

NOV 30 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 29 1945, at 6:20AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov.26 1944, to Nov.29 1945, and that I last saw him alive on Nov. 29 1945.

Immediate cause of death Pneumonia, bronchial, terminal, right lower lobe — Duration several days

Due to Carcinoma of left antrum with metastasis to dura and

Due to leptomeninges base of brain, anteriorly — Duration UNKNOWN

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon 11/29/45
Address Clinical Director US Marine Hospital, Balto, Md. Date signed

X

34633

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. 34633

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1303 Rye Avenue
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Isaac Weil

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Lucy J.

6 (c) If alien, give age years

7. Birth date of deceased (mo., day, yr.) July 25-1871

8. AGE: Years	Months	Days	If less than one day
74	4	5	hr. min.

9. Birthplace N. Y. C.
(Town, county, and state)

10. Usual Occupation Mech. Engineer

11. Industry or business

FATHER
12. Name Abraham Weil
13. Birthplace Germany

MOTHER
14. Maiden Name Emma Klein
15. Birthplace Germany

16 (a) Informant Lucy J. Weil
(b) Address 1303 Rye Ave

17 (a) Removal (b) Date thereof 11/30/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Arlington National
Location Virginia

18 (a) Funeral director J. H. Deneo Co
(b) Address Washington D. C.

NOV 30 1945
(Date rec'd by registrar)

Huntington Williams M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 30, 1945, at 9 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skotarelsky M.D.
Medical Examiner.
Date signed 11-30-45.

VS 151

GB1634
JL - 97563

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 92B

Registered No. GB1634

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1761 Montpelier St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dominic Joseph Presti

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-01-0568

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Rose
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 7, 1907

8. AGE: Years	Months	Days	If less than one day
38	8	21	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business Clothing

FATHER
12. Name Joseph Presti
13. Birthplace Italy

MOTHER
14. Maiden Name Angeline ?
15. Birthplace Italy

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 1, 1945 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4439 Belair Road

18 (a) Funeral director John J. Drebliznekas, Jr.
(b) Address 423 S. Paca St,

19 (a) NOV 30 1945 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 28 1945, at 7.10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 28 1945, to Nov. 28 1945, and that I last saw h im alive on Nov. 28 1945.

Immediate cause of death	Duration
Cardiac failure	?
Due to Rheumatic Heart Disease	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Mitral stenosis, hypertrophy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Margaret M. Davis M. D.
Address 4940 - Eastern Ave · Date signed 11-28-45

To be Approved by Medical Examiner.
For S. C. J. Subinski, by Howard J. Sheeler, M.D.

G34635

JL - 97408

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D ✓

G34635 Registered No.

Every item of information should be carefully supplied. The space WITH PLAINLY, WITH UNFADING INK. E... write the causes of death clearly and legibly. correct age is especially important. Physicians: please wr...

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals 46

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County 5

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 405 S. Cornwall St
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Peter Michael

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Hannah M. Rehmert

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 11. 1869

8. AGE: Years	Months	Days	If less than one day
75	11	16	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name John Michael
13. Birthplace ? Germany

MOTHER
14. Maiden Name Mary Quantt
15. Birthplace Md. Germany

16 (a) Informant: B. C. H. Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/30/45 (month) (day) (year)

(c) Cemetery or crematory Oak Lawn

Location 7225 Eastern Ave.

18 (a) Funeral director Clarence F. Hoffmann

(b) Address 1639 N. Broadway

NOV 30 1945 (b) Washington, D.C.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27 1945, at 1.20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 20 1945, to Nov. 27 1945, and that I last saw him alive on Nov. 27 1945.

Immediate cause of death	Duration
Myocardial failure	?
Due to Hypertensive Cardio-vascular disease	?
Due to	
Other Conditions Bronchopneumonia	?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Margaret M. Davis M. D.

Address 4940 Eastern ave. Date signed 11-27-45

X

G34636

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G34636

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5 E. Hamburg St.
(c) Hospital or institution: —

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 2 3
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5 E. Hamburg St. (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) **FULL NAME** Augusta Gottlieb (Gusta Gowtlieb)
3 (b) If veteran, name war —
3 (c) Social Security Account No. 213-01-9647

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Peter C. Gottlieb
6 (c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) Nov. 26, 1875

8. AGE: Years	Months	Days	If less than one day
70	—	3	hr. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

MOTHER | FATHER
12. Name August Deall
13. Birthplace Baltimore, Md.
14. Maiden Name Gertrude (?)
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Nettie E. Holland (Daughter)
(b) Address 10 E. Hamburg St. Balto 30, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 1, 1945 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Balto. Co., Md.

18 (a) Funeral director G. Howard Evans
(b) Address 1400 S. Charles St. Balto 30, Md.

19 (a) Huntington Williams, M.D. Registrar
(Date rec'd by registrar) NOV 30 1945 Vs 50

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 29, 1945, at 4:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/10 1944 to 10/20 1945 and that I last saw h[illegible] alive on 10/20 1945.

Immediate cause of death Cardio-vascular Collapse associated with arterio sclerotic heart disease — Duration 2

Due to —

Due to —

Other Conditions None

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? .....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature Harry Deall
Address 1326 Hanover St. Date signed 11/29/45 M. D.

Howard J. Wedeen, M.D.

634637

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

Registered No. 634637

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 421 East Lynn Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 421 East Lynne Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HARRY C. SANDERS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. --

6 (b) Name of husband or wife --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 8, 1941

8. AGE: Years 4 | Months 6 | Days 20 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Harry L. Sanders
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Mildred Carson
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. Mildred Sanders
(b) Address 421 East Lynne Avenue

17 (a) Burial (b) Date thereof Dec. 1, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Frederick Avenue

18 (a) Funeral director John Miller
(b) Address 2334 Jefferson Street

19 (a) NOV 30 1945 (Date rec'd by registrar) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 28, 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 7, 1945 to Nov. 28, 1945 and that I last saw him alive on Nov. 27, 1945

Immediate cause of death	Duration
Acute Myelogenous Leukemia	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Eugene A. Kupp

Address 3030 Edmondson Ave. Date signed 11/29/45 M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634638

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

634638 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1616 Harlem Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1616 Harlem Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Callene Miles Grant

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widow

6 (b) Name of husband or wife Thomas

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 4 1885

8. AGE: Years	Months	Days	If less than one day
60	9	24	hr. min.

9. Birthplace Balto County Md. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER 12. Name Callene Miles
13. Birthplace Culpepper Virginia

MOTHER 14. Maiden Name Malinda Bell
15. Birthplace Va.

16 (a) Informant Alice Mae Purcell
(b) Address 1616 Harlem Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 2 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Stephens Cem.
Location Essex Md.

18 (a) Funeral director Mrs. Robert A. Elliott & Dgt.
(b) Address 1129 E. Baseline St.

19 (a) NOV 30 1945 (b) (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 28 1945 at 8 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from July 10 1945 to Nov. 4 1945 and that I last saw him alive on Nov. 4 1945.

Immediate cause of death
Due to Prostate Gland Enlargement
Due to Arteriosclerotic Heart Disease
Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

Duration
2 weeks

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature R. V. Leitch Jr. M.D.
Address 426 N. Johnson Date signed Nov 29 1945

VS 150

G34639

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G34639 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1000 Eaton avenue
(c) Hospital or institution:
Jenkins Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 9 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1009 East Preston Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (Miss) Mary Glenn

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1856

8. AGE: Years 89 | Months - | Days | If less than one day hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Edward Glenn
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Grady
15. Birthplace Ireland

16 (a) Informant Jenkins Memorial Hospital
(b) Address 1000 eaton avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 1 '45 (month) (day) (year)
(c) Cemetery or crematory Mt. Cathedral Cem
Location 4300 Old Frederick Rd.

18 (a) Funeral director Elmer O. Conkling & Son
(b) Address 924 E. Lanvale St.

19 (a) (Date received by registrar) (b) Registrar
30 Nov 45 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 29 1945, at 11:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1, 1944 to 11-29-1945 and that I last saw h[illegible] alive on 11-29-45 19

Immediate cause of death: Cardio Resp. failure. — Duration

Due to: Arteriosclerotic Hypertension. C-V Dis.

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify yes or no) (Specify work or place)
(e) Means of injury

23. Signature Thos. J. Carroll Jr. M. D.
Address 924 Eager St. Date signed 11/30/45

Direct age is especially important. Physicians: please write the

G34640 BALTIMORE CITY HEALTH DEPARTMENT G34640

CERTIFICATE OF DEATH 32a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County A. A. Co.
(c) City or town Odenton Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. —
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Maude P. Hopkins

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Edgar Hopkins

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-24-85

8. AGE: Years 60 Months 1 Days 5 If less than one day hr. min.

9. Birthplace Md (Town, county and state)

10. Usual Occupation Clerk

11. Industry or business War Department

FATHER 12. Name Caleb J. Pierce

13. Birthplace Md

MOTHER 14. Maiden Name Sarah A. Pierce

15. Birthplace Md

16 (a) Informant Records.

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 3-1945 (month) (day) (year)

(c) Cemetery or crematory Jesuits

Location Baltimore Co. Maryland

18 (a) Funeral director Dugger Funeral Home

(b) Address 3631 Falls Road

19 (a) (b)
(Date rec'd by registrar)

VS NOV 30 1945 Hunting for Williamsport

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 29 1945 at 5 40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 23 1945 to Nov. 29 1945 and that I last saw h alive on Nov 29 1945

Immediate cause of death CARDIAC failure — Duration

Due to Adeno Carcinoma & Epidermoid Carcinoma Kidney

Due to with abdominal metastases

Other Conditions Kidney Stones

(Include pregnancy within 3 months of death)

Date of operation Oct. 13, 1945

Major findings of operation: CARCINOMA Kidney Right

of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James E. Davis M.D.

Address Johns Hopkins Hosp. Date signed 11-29-'45

PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34641

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G34641
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Ave.
(c) Hospital or institution:
St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3403 Park Lawn
(e) Citizen of foreign country? Poland (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Frances Shiroky

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 9 1878

8. AGE: Years	Months	Days	If less than one day
67	8	19	hr. min.

9. Birthplace Europe (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Schiroky
13. Birthplace Europe

MOTHER
14. Maiden Name Not Known
15. Birthplace Europe

16 (a) Informant Francis Vaughn
(b) Address 3403 Park Lawn Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 1-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto

18 (a) Funeral director Jos. J. Stein & Son
(b) Address 2401 Kentucky ave

19 (a) (Date received by registrar) (b) City or Town Williamsburg

NOV 30 1945

VS-NO

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/28/45 1945, at 4:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/24 1945 to 11/28 1945, and that I last saw her alive on 11/28 1945

Immediate cause of death	Duration
Cardiac Resp. Failure	
Due to Massive Cerebral Hemorrhage.	
Due to Hypertension C-V Dis.	
Other Conditions Left Sided Hemiplegia	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chas. E. Earl M.D.
Address St Agnes Hosp. Date signed 11/28/45

X

6010.8

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

74a

Registered No. G34642

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ~~[illegible]~~
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County city
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2827 Chesterfield Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Ivan Elwood Jenkins
3 (b) If veteran, name war
3 (c) Social Security Account No. 255-01-3257

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Married

6 (b) Name of husband or wife Mrs. Marie C. Jenkins
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Oct 27, 1899

8. AGE: Years	Months	Days	If less than one day
48 48	1	1	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Clerical
11. Industry or business Raymond Concrete Pile Co.

FATHER
12. Name Gustavis Jenkins
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth Johnson
15. Birthplace Md.

16 (a) Informant Wife
(b) Address 2827 Chesterfield Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 3-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto

18 (a) Funeral director J. J. Hines + Son
(b) Address 3801 Kentucky Ave

19 (a) Dec 3 1945 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 28 1945, at 6:53 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 24 1945, to Nov. 27 1945, and that I last saw him alive on Nov. 27 1945

Immediate cause of death	Duration
Cerebral Embolism	4 days
Due to Coronary thrombosis	1 yr.
Due to Progressive cerebral lesions	after
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Paul R. Meyer M. D.
Address Mercy Hospital Date signed 11-29-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

Huntington Williams, M.D.

X (5)

Every item of information should be carefully supplied. Age is especially important. Physicians: please write the causes of death clearly and legibly.

G34643 ✓ G34643

TN. 96934

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-month & 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 208 N. Stricker St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Adam Walker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lucille

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 6th, 1900

8. AGE: Years 45 | Months 8 | Days 22 | If less than one day ... hr. ... min.

9. Birthplace S. C
(Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

FATHER
12. Name Manley Walker
13. Birthplace S. C

MOTHER
14. Maiden Name Janie Moody
15. Birthplace South Carolina

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Removal (b) Date thereof 12-1-41
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sumter
Location S. C.

18 (a) Funeral director Isaac L. Brown & Son
(b) Address 108 N. Montgomery St

19 (a) (b)
(Date rec'd by registrar) Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 28th 1945 19..., at 5.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-29-45 19..., to 11-28- 19 45, and that I last saw h... in alive on Nov. 28 19 45

Immediate cause of death: Meningococcus Septicemia — Duration: ?

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation: none

of autopsy: not reported yet

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at ... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature T. P. Jernigan M. D.
Address Baltimore City Hosp. Date signed 11-30-45

X

G34644

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 126

Registered No. G34644

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lanvale & Johns street
(c) Hospital or institution: Hospital for women of Maryland 25
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1348 cambria st
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Martha Martha Hewson

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	Married.

6 (b) Name of husband ~~or wife~~ James J. Hewson
(c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) 57 yr

8. AGE: Years	Months	Days	If less than one day
51			hr. min.

9. Birthplace Pattersville MD.
(Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name Nathan Yester
13. Birthplace ? Maryland

MOTHER
14. Maiden Name Lydia Baetic
15. Birthplace ? maryland

16 (a) Informant Hospitals
(b) Address

17 (a) Burial (b) Date thereof Dec 3-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Crumpton
Location Crumpton Md

18 (a) Funeral director Edgar L Lane
(b) Address Church Hill Md

NOV 30 1945
(Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 30 1945, at 3 00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/17/45 19 to 11/30 19 45, and that I last saw h~~im~~er alive on 11/30 19 45

Immediate cause of death	Duration
Cardio Resp victory failure	
Due to Cardiac Insufficiency	3 days
a month acute pulmonary edema	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 11/21/45
Major findings of operation: Acute Cholecystitis & cholelithiasis
of autopsy: Hypertension & Arteriosclerosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature John M Pelton M.D.
M. D.
Address Hospital for women md Date signed 11/30/45

G34645

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G34645
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2713 W. Lafayette ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2713 W. Lafayette ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ella M. Davidson

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Thomas C. Davidson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 11th 1887

8. AGE: Years 58 | Months 2 | Days 18 | If less than one day: hr. min.

9. Birthplace A. A. Co. Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name John S. Cadle
13. Birthplace Unknown

MOTHER
14. Maiden Name Rebecca Tucker
15. Birthplace A. A. Co. Md.

16 (a) Informant Thos. C. Davidson (Husband)
(b) Address 2713 W. Lafayette Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/3/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) Date rec'd by registrar DEC 1 1945 Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 29th 1945, at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1, 1945 to Nov. 29 1945; and that I last saw h[illegible] alive on Nov 29, 1945.

Immediate cause of death: Arteriosclerotic Cardio-vascular Renal Disease — Duration
Due to: Diabetes Mellitus
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Samuel B. Wolfe, M.D.
Address 1331 North Ave Date signed 11-30-45

VS 150

X

G34646

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 12

Registered No. G34646

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lakeland and Harper
(c) Hospital or institution: W B C T
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2d 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 2314 Sidney Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Millecker (Millekr)

3 (b) If veteran, name war NO

3 (c) Social Security Account No. 214-12-8003

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept 6 1924

8. AGE: Years 21 | Months 7 | Days 23 | If less than one day ..... hr. ..... min.

9. Birthplace New Jersey (City, county, and state)

10. Usual Occupation welder

11. Industry or business Standard Gas & E. Co

FATHER 12. Name John Millecker

13. Birthplace Hungary

MOTHER 14. Maiden Name Louise Darcy

15. Birthplace N. J.

16 (a) Informant Mrs. Louise Maurer

(b) Address 2314 Sidney ave

17 (a) Burial (Burial, ~~cremation~~, or removal) (b) Date thereof 12/4/45 (month) (day) (year)

(c) Cemetery ~~or crematory~~ London Park

Location Balto. Md.

18 (a) Funeral director William Cook Inc

(b) Address 1217 St. Paul St

19 (a) DEC 1 19 (Date received by registrar) Huntington Williams M.D. Registrar

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 29 1945, at 9 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-27 1945, to 11-29 1945, and that I last saw h alive on 19.

Immediate cause of death	Duration
Uremia	
Due to Chronic nephritis	about 2 wks
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Small bilateral granular kidneys, moderate heart enlargement

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James A. Dawson M.D.
Address W. 13 C St. Date signed 11/29/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G31647

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. G31647

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd + Calvert St.
(c) Hospital or institution: Union Memorial Hospital 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
14 City or town Baltimore. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3914 White Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. William Redding Harvey, Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mrs. Maude L. Harvey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 15, 1871

8. AGE: Years	Months	Days	If less than one day
74	7	14	hr. min.

9. Birthplace Illinois (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER
12. Name Mr. Eli Harvey
13. Birthplace Illinois

MOTHER
14. Maiden Name Anna Woodward
15. Birthplace Illinois

16 (a) Informant Records
(b) Address Union Memorial Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/2/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Monkton Md
Location

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 DEC 1 1945 (Date rec'd by registrar) (Signature of registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 29 1945, at 9:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 27, 1945, to Nov 29, 1945, and that I last saw him alive on Nov. 29, 1945.

Immediate cause of death Coronary Thrombosis — Duration

Due to

Due to

Other Conditions Arterio-sclerotic Cardio-Vascular Disease. (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Frank Supplee Jr.
Address Union Memorial Hospital Date signed 11/29/45 M. D.

VS 150

G34648

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1157

G34648
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Redgrave + Greene
(b) Street address 818 Lemmon St
(c) Hospital or institution:
Univ of MD - Hospital - 18 - 5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 mos
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County Balt
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 818 Lemmon St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Lucky.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced. Single ?

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years 52 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace ?
(Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Annie Reynolds -
(b) Address ?

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School NOV 30 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 DEC 1 1945 (Date rec'd by registrar) Hunter for Williams M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-22-1945, at 11 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-22-1945 to 11-22-1945, and that I last saw h[illegible] alive on 11-22-1945.

Immediate cause of death Chronic anginia — Duration

Due to Ludwig Angina

Due to Con. impeded Throat

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George P. Callender M. D.
Address Univ Hosp Date signed 11-27-45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3114

634649

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. 634649

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3031 McElderry Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3031 McElderry Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME FREDERICK WILLIAM BECHTOLD

3 (b) If veteran, name war: no
3 (c) Social Security Account No. 215-01-5203

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary Schuch Bechtold
6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) Oct. 29, 1876

8. AGE: Years 69 | Months 1 | Days 0 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Foreman-finisher
11. Industry or business Geo. Spindler. net. 4yrs.

FATHER
12. Name William Bechtold
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Christina Bauer
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Mary S. Bechtold
(b) Address 3031 McElderry Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-3-45 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 Date rec'd Dec 1 1945 (b) Registrar's signature Huntington Williams Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH November 29, 1945, at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1945 to Nov 29 1945; and that I last saw him alive on Nov 28 1945.

Immediate cause of death Congestive failure, edema
due to Myocarditis — Duration

Due to — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Franklin Hazlehurst M. D.
Address 2512 E Monument St Date signed
Baltimore Md

~~4334710~~ 97510

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1497 Registered No. G31650

Every item of information should be carefully supplied. Write plainly with INDELIBLE INK. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern
(c) Hospital or institution: Baltimore City Hospitals 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3643 Keswick Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Elizabeth Triplett

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Gilbert Triplett
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 8, 1920

8. AGE: Years	Months	Days	If less than one day
25	1	22	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Allen Andrew Kilmore.
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Blouse
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 3 1945 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Harford Road.

18 (a) Funeral director Kenneth + Donovan
(b) Address 3615 Eastern Ave.

19 (a) Date rec'd by registrar DEC 1 1945 Hospital for Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 30 1945, at 8:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 26 1945, to Nov. 30 1945, and that I last saw h er alive on Nov. 30 1945.

Immediate cause of death	Duration
Shock of Uraemia.	
Due to Mental Disease.	
Due to	
Other Conditions (over)	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature David T. Rees M. D.
Address 3 C [illegible] Date signed 12/3/45

DAVID T. Rees. M.D. X

634651

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 634651

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4608 Roland ave
(c) Hospital or institution:
27-14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 28 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 4608 Roland ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret E. Dugas

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	widow

6 (b) Name of husband or wife ✓

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 1864

8. AGE: Years	Months	Days	If less than one day
80	11		hr. min.

9. Birthplace Georgia (Town, county, and state)

10. Usual Occupation

11. Industry or business —

FATHER
12. Name Thomas Barrett
13. Birthplace Ga

MOTHER
14. Maiden Name Arrington Hare
15. Birthplace Ga

16 (a) Informant Grace A. Dugas
(b) Address 4608 Roland ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 1945 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Askewille, Balto. Co.

18 (a) Funeral director John O. Middlemiss
(b) Address 4004 Eutaw Place —

19 (a) DEC 1 - 1945 (Date rec'd by registrar) Huntington Millard Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/29 1945, at 11 30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 1938, to 11/29 1945; and that I last saw her alive on 11/29 1945;

Immediate cause of death Myocarditis
Arterio-Sclerosis — Duration Several

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W H Moody M.D.
Address 1403 Park ave Date signed 11/30/45

VS 190

X

G34652

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

G34652 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6216 Monaway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elma Coleman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-18-70

8. AGE: Years 75 | Months 1 | Days 11 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Josiah Massey
13. Birthplace Md

MOTHER 14. Maiden Name Annie Evans
15. Birthplace Md

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 1 45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 1900 Eutaw Place

19 (Date received by registrar) DEC 1 1945 Huntington Willemin, Registrar

VS 15C

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 29 1945 at 5:22 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 22 1945 to Nov 29 1945 and that I last saw her alive on Nov 29 1945

	Duration
Immediate cause of death: Cardiac failure	24 hrs
Due to: Operative removal uterus + ovarian tumor	
Due to: Carcinoma ovary with extensive metastases	6 months
Other Conditions: ? Sarcoma uterus	

(Include pregnancy within 3 months of death)
Date of operation November 24, 1945
Major findings of operation: Extensive carcinoma, ovary
of autopsy: Not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature David B. Cheek M. D.
Address Johns Hopkins Hospital Date signed 11/29/45

X

634653

483778

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No. 634653

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17-3
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 814 Harlem Ave. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Clarence L. Gordon

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Mary C.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-25-95

8. AGE: Years 50 49 | Months 3 | Days 3 | If less than one day .....hr. .....min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Laborer.

11. Industry or business

FATHER 12. Name John Gordon
13. Birthplace Md.

MOTHER 14. Maiden Name Mary Mollock
15. Birthplace Md

16 (a) Informant Rhonda.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 2, 1945 (month) (day), (year)
(c) Cemetery or crematory Woodlawn Mem. Park
Location Baltimore, Md.

18 (a) Funeral director Chas. H. Hyland
(b) Address 1631 Druid Hill Ave.

DEC 1 - 1945 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION A

20. DATE OF DEATH Nov 28 1945, at 1245 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 16 1945, to Nov. 28 1945, and that I last saw him alive on Nov 25 1945

Immediate cause of death Carcinomatosis
Generalized debilitation

Duration

Due to Carcinoma, Primary site unknown.

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

Date of operation 11-17-45

Major findings of operation Generalized carcinomatosis.

of autopsy.....

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence.....at..... M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....

23. Signature W. H. Mueller M.D.

Address The Johns Hopkins Hospital Signed 11-28-45

VS 150

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

3365A - 96679

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83B

Registered No. 631654

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 15-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) 26 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1704 McKean Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Faulkner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Beatrice
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 8, 1900

8. AGE: Years	Months	Days	If less than one day
45	3	20	hr. min.

9. Birthplace S. C.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name George Faulkner
13. Birthplace S. C.

MOTHER
14. Maiden Name Mary Alice Hood
15. Birthplace S. C.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof Dec. 4, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount Mem. Park
Location Baltimore, Md.

18 (a) Funeral director Thos. Lew. H. Holland
(b) Address 1631 David Hill Ave.

DEC 1 - 1945
(Date rec'd by registrar)

Huntington Williams, M.D.

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 28 1945, at 9.50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 15 1945, to Nov. 28 1945, and that I last saw him alive on Nov. 28 1945.

Immediate cause of death	Duration
Bronchopneumonia	
Due to Cerebral thrombosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: none
of autopsy: Bronchopneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature T. P. Jerrigan M. D.
Address Baltimore City Hosp. Date signed 11-29-45

PRINT WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

~~34655~~

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157E

Registered No. G34655

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. Try to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wash Blvd & Bartlett
(c) Hospital or institution: Does Maternity Hos
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 706 Bartlett Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lois Frances Wentz

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	White	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 27/45

8. AGE: Years	Months	Days	If less than one day
		3	hr. min.

9. Birthplace Balto
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Lewis Wentz
13. Birthplace Pa

MOTHER
14. Maiden Name Anna Hess
15. Birthplace Balto

16 (a) Informant Mrs Frank Murphy
(b) Address 1728 N Smallwood St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 1/45 (month) (day) (year)
(c) Cemetery or crematory Catherdral
Location Balto

18 (a) Funeral director Welsh Funeral Home
(b) Address 2008 Orleans St

19 DEC 1 - 1945 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-30-1945, at 11A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-27-1945, to 11-30-1945, and that I last saw h[illegible] alive on 11/30 1945.

Immediate cause of death Congenital Heart Disease — Duration

Due to —

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis J Slagle M.D.
Address 976 Arlington Ave Date signed 12/1/45

VS 150

G34656

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1170C

Registered No. G34656

Please write the causes of death clearly and legibly. Physicians: please write the correct age in capacity important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: Provident Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 7 8 1/2 mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 810 N. Calhoun Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Willis

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: W

6 (b) Name of husband or wife: Bertha

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1869

8. AGE: Years 76 | Months | Days | If less than one day hr. min.

9. Birthplace md
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Edward Willis
13. Birthplace md

MOTHER
14. Maiden Name Charlotte ?
15. Birthplace md

16 (a) Informant Raymond Willis
(b) Address 1508 Caroline St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/4/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Md.

18 (a) Funeral director Mrs. S. Kelson
(b) Address 1303 Preastman St.

19 DEC 1 - 1945 (Date rec'd by reg.) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 30, 45, at 8:40 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Pelvis; Compound Contaminated Fractures of Lower Legs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-26-45 at 12:25 A.M. 16/2
(b) Where did injury occur? 800 block of N. Calhoun St.
(c) Did injury occur at home, on farm, industrial place, in public place? In front of home. While at work? No.
(d) Means of injury? Pedestrian struck by auto.

23. Signature Robert L. Traphagen M.D.
Medical Examiner.
Date signed November 30, 1945.

VS 151

G34657

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G34657

1. PLACE OF DEATH: 2565 Edmondson Ave.
(a) Baltimore City, Maryland
(b) Street address 2565 Edmondson Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 D
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2565 Edmondson Av (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME John Henry Grauling.

3 (b) If veteran, name war —

3 (c) Social Security Account No. 212-16-9926

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Augusta Grauling

6 (c) If alive, give age yrs

7. Birth date of deceased (mo., day, yr.) March 15, 1870

8. AGE: Years 75 | Months 8 | Days 14 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Machinist.

11. Industry or business Elliott Machine Corp.

FATHER
12. Name Unknown
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Augusta Grauling
(b) Address 2565 Edmondson Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 3, 1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Ave. Balto. Md.

18 (a) Funeral director George Weber & Son
(b) Address 2583 Edmondson Ave.

19 (a) DEC 1945 (Date received by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 29, 1945, at 11 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-27- 1945, to 11-29- 1945, and that I last saw him alive on 11-27- 1945.

Immediate cause of death: Coronary Thrombosis — Duration: a few minutes

Due to:

Due to:

Other Conditions: Bronchitis — 1 week

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chester Riland, M.D.

Address 2582 Edmondson Ave. Date signed 11-30-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

634658

Th.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓186a

Registered No. 631658

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16- 8- 1 day

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1611 Llewelyn Ave
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Ibex

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife George Ibex (D

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 10th 1868

8. AGE: Years	Months	Days	If less than one day
77	9	17	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Shirt Presser

11. Industry or business

FATHER
12. Name George Kennedy
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Leonard
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-1-45 (month) (day) (year)

(c) Cemetery or crematory Balto.
Location East North Ave

18 (a) Funeral director Mart W. E. Rippel

(b) Address 37 S [illegible] St

DEC 1 - 1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 27th, 1945 19 , at 5.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 26. 1929, to Nov. 27. 1945. and that I last saw h. alive on Nov 27th, 1945

Immediate cause of death Hypostatic pneumonia

(Duration)

Due to fractured femur Mallorca 2 days

Due to Senile debility

Due to chronic glomerulonephritis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy: chronic glomerulonephritis

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 26/12

(a) Accident, suicide, or homicide Acc

(b) Date of occurrence Nov. 25 1945 M

(c) Where did injury occur? Baltimore City Hos
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? Hospital While at work? No
(Specify type of place)

(e) Means of injury Fell to floor in Hospital

23. Signature Ed Pfeiffer M. D.

Address B.C.H. Date signed 11-30-45

To be approved by Medical Examiner
Robert Lee Graham M.D. X 12/1/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item or information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34659 / 483942

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH / 1240

G34659 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully obtained. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 13 N. Washington St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Novotny

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife [redacted] CATHERINE
6 (c) If alive, give age 95 years

7. Birth date of deceased (mo., day, yr.) 2-10-87

8. AGE: Years	Months	Days	If less than one day
58	9	18	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Sheet Metal Worker
11. Industry or business

FATHER
12. Name John Novotny
13. Birthplace Lohecz.

MOTHER
14. Maiden Name Marian Mikosh
15. Birthplace Lohecz.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 3 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location City

18 (a) Funeral director Wilmot Funeral Home
(b) Address 2008 Orleans St

DEC 1 - 1945 (Date rec'd by Registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 28 1945, at 6.50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/19/45 1945 to 11/28/45 1945 and that I last saw h[illegible] alive on Nov 28 1945.

Immediate cause of death: Bronchio pneumonia — Duration 10 days
Due to Cause not determined
Due to
Other Conditions Hepatic Cirrhosis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Philip A. Kennedy M.D.
Address Johns Hopkins Hospital Date signed 11-29-45

VS 150

(over)

107

G34660

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G34660

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1029 W. Cross St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2T-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1029 W. Cross St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Catherine Gaynor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex female | 5. Color or race white | 6 (a) Single, married, widowed, or divorced. widow

6 (b) Name of husband or wife Late Patrick

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown. 1861

8. AGE: Years 84. | Months | Days | If less than one day hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation house work

11. Industry or business at home

FATHER 12. Name Martin Giles

13. Birthplace Ireland

MOTHER 14. Maiden Name Ann Leary

15. Birthplace Ireland

16 (a) Informant Mrs Lemuline Gaynor

(b) Address 2121 Biddle St, Wilmington Del

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/3/45 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location 4300 Old Frederick Road

18 (a) Funeral director Hugh Conway & Son

(b) Address 901-03 Hollins St

DEC 1 - 1945 (Date rec'd by registrar)

(b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION 11/29/45

20. DATE OF DEATH 11/24 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1945 to Nov 29 1945, and that I last saw h.. alive on Nov 29 1945.

Immediate cause of death	Duration
PULMONARY EDEMA	48 hrs
cardiac failure	48 hrs
Due to arteriosclerotic heart disease	years ?
Due to	
Other Conditions generalized arteriosclerosis, senility	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert J. Glass M. D.

Address 874 Wash Blvd. Date signed 30 Nov 1945

VS 150

X

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

G34661

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 54B

Registered No. 634661

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2031 Sinclair Lane
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2031 Sinclair Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emil Berkowski

3 (b) If veteran, name war

3 (c) Social Security Account No. 705-09-1751

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Lena E. Berkowski
6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) July 29, 1890

8. AGE: Years	Months	Days	If less than one day
55	4	11	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Engineer
11. Industry or business B. & O. R. R.

FATHER
12. Name John Berkowski
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Lena E. Berkowski
(b) Address 2031 Sinclair Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 3, 1945 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location North Ave.

18 (a) Funeral director John C. Miller Inc.
(b) Address 2435 E. Oliver St.

19 (a) DEC 1 - 1945 (b) Washington Williams, M.D. Registrar
Date received by Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 20 1945; at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 7 1945 to Nov 22 1945; and that I last saw h alive on Nov 25 1945.

Immediate cause of death	Duration
Malignant Neoplasm	
Due to Tumors	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation In last week
Major findings of operation Duke
J. H. Hartsuch
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence None at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John A Evans M. D.
Address 6 E W 40 St Date signed

VS 150

G34662 G34662

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No.

Please write plainly, with UNFADING INK. Every item of information should be carefully supplied. Where correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2208 W Mulberry St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2208 W. Mulberry St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Richard Dutton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widower

6 (b) Name of husband or wife Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 14, 1879

8. AGE: Years	Months	Days	If less than one day
66	4	14	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name Charles Dutton
13. Birthplace Md.

MOTHER
14. Maiden Name Lucinda Thompson
15. Birthplace Md

16 (a) Informant Ida E. Snowden
(b) Address 1129 N Carrollton St

17 (a) Burial (b) Date thereof Dec 1, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Laurel Cemetery
Location Elm Ln

18 (a) Funeral director Wm. Robert G. Elbert & Son
(b) Address 1129 N. Eutaw St.

DEC 1 - 1945 Huntington Williams M.D.
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 28 1945 at 8:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 8, 1945 to Nov 28 1945 and that I last saw h[illegible] alive on Nov 27, 1945

Immediate cause of death Carcinoma of renal disease — Duration Six mos.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John E. J. Campfer M. D.

Address 639 N. Carey St Date signed 11-29-45

VS 150

4663

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1476

Registered No. 634663

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd + Calvert Sts.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Harford
(c) City or town Joppa
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Charles William Bachman (Marie) Bachmann

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Charles William Bachman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 3, 1918

8. AGE:	Years	Months	Days	If less than one day
	27	9	28	..... hr. ..... min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name Vincent Jostonski
13. Birthplace Maryland.

MOTHER
14. Maiden Name Mary ?
15. Birthplace Maryland

16 (a) Informant Mr C. H. Bachman
(b) Address Joppa, Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/4/45 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location V Mapes

18 (a) Funeral director Chas E Grosso.
(b) Address Benson Md.

DEC (a) 1 - 1945 (b) Huntington Williams M.D.
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 1, 1945, at 5 50 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from November 30 1945, to December 1, 1945 and that I last saw her alive on December 1, 1945.

Immediate cause of death Puerperal Sepsis (possible) — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Frank Supplee III
Address Union Memorial Hospital Date signed 12/6/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully obtained. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

631664

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131B

Registration No. 631664

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2239 E.Chase St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2239 E.Chase St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Preston Richard Knopp

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 20,1911

8. AGE: Years	Months	Days	If less than one day
34	5	18	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Shipping Clerk
11. Industry or business H.B.Davis Paint Co.

FATHER
12. Name George Knopp
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Mary Donnolly
15. Birthplace Baltimore Md.

16 (a) Informant Mrs.Josephine Knopp
(b) Address 2239 E.Chase St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/3/45 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Frederick Rd.

18 (a) Funeral director Clarence F.Hoffmann
(b) Address 1639 N.Broadway

19 (a) (Date rec'd by registrar) (b) (Signature of Registrar)

DEC 1 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 29 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1 1942, to Nov. 29 1945, and that I last saw him alive on Nov. 28 1945.

Immediate cause of death	Duration
Rheumatic Cardiac Vascular Disease	15 yrs?
Due to with Decompensation	
Due to Chronic Glomerular nephritis	1 year
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Karl Grennan M. D.
Address 1212 N. Patterson Pk Ave Date signed 11/30/45

G34655

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G34655 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Balto. City Hospitals 11-

(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 111 N Guilford Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME David M. Johnson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Lula Hyrich

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 2, 1890 1890

8. AGE: Years	Months	Days	If less than one day
55	—	28	hr. min.

9. Birthplace Guilford Co., N. C.
(Town, county, and state)

10. Usual Occupation Cooper

11. Industry or business Empire Re-roofing Co.

FATHER
12. Name H. H. Johnson
13. Birthplace

MOTHER
14. Maiden Name Mary Jane Appel
15. Birthplace

16 (a) Informant Elwood Johnson
(b) Address Gibsonville, N. C.

17 (a) Removal (b) Date thereof 12/1/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Burlington, N. C.
Location

18 (a) Funeral director W. J. Tucker & Sons
(b) Address Baltimore, Md.

DEC 1 - 1945 (b) [illegible] Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-30- 1945, at 3 40 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Arteriosclerosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Weaver M.D.
Medical Examiner.
Date signed 12-1-45

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34666

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G34666

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 637 N. Calhoun Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 637 N. Calhoun Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James E. Brooks

3 (b) If veteran, name war

3 (c) Social Security Account No. 213 0

4. Sex: Male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-26-1881

8. AGE: Years 64 | Months 9 | Days 4 | If less than one day hr. min.

9. Birthplace Va Md. (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name Edward Brooks
13. Birthplace Md

MOTHER
14. Maiden Name Beatrice Smith
15. Birthplace Md

16 (a) Informant Laura Thompson
(b) Address 637 N. Calhoun St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-4-45 (month) (day) (year)
(c) Cemetery or crematory Clarks Chapel Cemetery
Location Belair Md.

18 (a) Funeral director Adolphus Halstead
(b) Address 915 Wheat Hill Ave.

19 (a) DEC 1 - 1945 (Date rec'd by Registrar) (b) Huntingtown Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 30 1945, at P. M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion
cardiovascular disease

Due to

Other Conditions Emaciation

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Fentress M.D. Medical Examiner.
Date signed November 30, 1945.

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34667

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

161a

Registered No. G34667

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp. 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 505 Orchard St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Wilson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Col	Baby

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
			½ hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Baby

11. Industry or business

FATHER
12. Name James Wilson
13. Birthplace South Carolina

MOTHER
14. Maiden Name Jane Wilson
15. Birthplace South Carolina

16 (a) Informant James Wilson
(b) Address 505 Orchard St.

17 (a) Burial (b) Date thereof 12-1-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Albion Cemetery
Location Md.

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

19 (a) DEC 1 - 1945 Huntington Williams
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-29- 1945 at 11:45 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Atelectasis Neonatorum

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed 11-30-45

G34668

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170c

Registered No. G34668

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 12 12
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2616 Bruce Terrace (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Rosetta Fortune

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Wm. Thomas Fortune

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 28 1898

8. AGE: Years 47 48 | Months | Days 2 | If less than one day ..... hr. ..... min.

9. Birthplace Balto Co (Town, county, and state)

10. Usual Occupation Laundry Worker

11. Industry or business .....

FATHER
12. Name Robert Moore
13. Birthplace Va

MOTHER
14. Maiden Name Catherine Hunter
15. Birthplace Balto Co.

16 (a) Informant Wm Thos. Fortune
(b) Address 2616 Bruce Terrace Balto.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 4-45 (month) (day) (year)
(c) Cemetery or crematory St Johns
Location Balto Co.

18 (a) Funeral director J. F. Elmes Sons
(b) Address Westminster

DEC 1 - 1945 (Date rec'd by registrar)

(b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 30, 1945, at 5:20 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured Skull

Due to .....

Other Conditions Multiple abrasions & contusions.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Nov. 30, 1945 at 5 20 P.M. 27/10
(b) Where did injury occur? York Rd. 160' north of Beaumont Avenue
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No.
(d) Means of injury Pedestrian struck by auto.

23. Signature Howard J. Mueller M.D. Medical Examiner.
Date signed 12-1-45

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34669

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1417

Registered No. G34669

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1007 S. Carey St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1007 S. Carey St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Elizabeth Johnston

3 (b) If veteran, name war —

3 (c) Social Security Account No. 216-18-9523

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	W	married

6 (b) Name of husband or wife Frederick P. Johnston
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 29, 1907

8. AGE: Years	Months	Days	If less than one day
38	7	29	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Home Duties
11. Industry or business

FATHER
12. Name James H. Lewis
13. Birthplace Baltimore

MOTHER
14. Maiden Name Ella M. Lathe
15. Birthplace Baltimore

16 (a) Informant Frederick Johnston
(b) Address 1007 S. Carey St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 1, 1945 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore

18 (a) Funeral director Frederick A. Dold
(b) Address 120 N. Lombard St

19 (a) Dec 1 1945 (Date received by Local Registrar) (b) Filed for Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/28 1945, at 5:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/24 1945 to 11/28 1945 and that I last saw h alive on 11/28 1945.

Immediate cause of death Meningococcic abortion — Duration 4 days.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Benjamin Miller MD
M. D.
Address 2030 Wilkens Date signed 11/30/45

VS 150

634670

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 634670

Every item of information should be carefully written. Physicians: please write the causes of death clearly and legibly. Be sure correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1600 Madison Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1600 Madison Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Hattie Mitchell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 5, 1906

8. AGE: Years 39 | Months 3 | Days 25 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Housemaid

11. Industry or business

FATHER
12. Name John T. Mitchell
13. Birthplace Va.

MOTHER
14. Maiden Name Angeline Earley
15. Birthplace Va

16 (a) Informant Georgia Walker
(b) Address 1019 Madison Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-1-45 (month) (day) (year)
(c) Cemetery or crematory Glascow
Location Virginia

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave

DEC 1 - 1945 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 30, 1945 at 3:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/24 1945 to 11/30 1945, and that I last saw her alive on 11/29 1945

Immediate cause of death: Influenza — Duration: 6 days
Due to
Due to
Other conditions: Hypertension Myocarditis (Chr) — Duration: 7
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. T. Howell M. D.
Address 601 N. Carrollton Ave Date signed 12/4/45

VS 150

320

G34671 BALTIMORE CITY HEALTH DEPARTMENT X ✓ G34671 71

CERTIFICATE OF DEATH 131a

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green Sts
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Freeland (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Palmer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Anna C. Palmer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 9, 1878

8. AGE: Years	Months	Days	If less than one day
67	8	22	hr. min.

9. Birthplace Balto Co. Md. (Town, county and state)
10. Usual Occupation Retired Engineer
11. Industry or business R.R.

FATHER
12. Name Louis Palmer
13. Birthplace Md.

MOTHER
14. Maiden Name Susan Brown
15. Birthplace Md.

16 (a) Informant Howard M. Palmer
(b) Address Hagerstown, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 4, 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion Cemetery
Location Freeland, Balto Co. Md.

18 (a) Funeral director Jacob Hartman
(b) Address New Freedom, Pa.

19 (a) (b) for Williams, M.D.
(Date received by registrar) Registrar

DEC 2 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 1, 1945 at 9:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/29/1945 to 12/1/1945 and that I last saw him alive on Dec 1 1945.

Immediate cause of death Pulmonary edema

Due to Uremia

Due to Ch. fibrosis of kidneys, arteriosclerosis & hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 12/4/45

X

634672

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

634672 Registered No.

Type or print plainly with pen. Do not write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D-0-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 506 Orkney Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles F. Brennels

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-07-8760

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 19-1871

8. AGE: Years	Months	Days	If less than one day
74	1	11	hr. min.

9. Birthplace Balto. Md. (Town, county, or state)
10. Usual Occupation Metal Worker
11. Industry or business

FATHER
12. Name Phillip Brennels
13. Birthplace Balto.

MOTHER
14. Maiden Name Fannie Bormett
15. Birthplace Balto. Md.

16 (a) Informant Margaret Brennels
(b) Address 506 Orkney Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 3-45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd.

18 (a) Funeral director John A. Meehan
(b) Address 3600 E. Baltimore St.

19 (a) DEC 2 - 1945 (Date received by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-30- 1945, at 9:5 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mellegis M.D. Medical Examiner.
Date signed 11-30-45

VS 151

JL - 97513 C34673

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13

Registered No. 5

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1503 Filbert St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James John Tobar

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 18, 1899

8. AGE: Years	Months	Days	If less than one day
46	0	11	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Helper
11. Industry or business U. S. Coast Guard

FATHER
12. Name James John Tober
13. Birthplace Germany

MOTHER
14. Maiden Name Elenora Krammer
15. Birthplace Germany

16 (a) Informant B. C. H. records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 12/2/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Cross R. A. Co.
Location Annapolis Blvd

18 (a) Funeral director John T. Denny Inc
(b) Address 711 Light St.

19 (a) DEC 2 - 1945 (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 29, 1945, at 2.15am M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 26 1945, to Nov. 29 1945, and that I last saw him alive on Nov. 29 1945.

Immediate cause of death Pulmonary Tuberculosis — Duration ?
Due to
Due to
Other Conditions Portal Cavities
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert B. Copeland Jr. M. D.
Address Balt. City Hosp. Date signed 11/29/45

X

Any item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34674 ✓ G34674

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122B

Registered No.

G34674

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Levindale Home
(c) Hospital or institution:
Belvedere Ave & Greenspring Ave
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 53 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Levindale Home
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rebecca Aaronson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Late Isaac

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1871

8. AGE: Years 74 | Months | Days | If less than one day hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER
12. Name Moses Gutkin
13. Birthplace Russia

MOTHER
14. Maiden Name Rachael Heneson
15. Birthplace Russia

16 (a) Informant Herman I Aaronson
(b) Address 3309 Burleith Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof December 2, 1945 (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cemetery
Location Hamilton Ave

18 (a) Funeral director Sol, Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) 12-3-1945 (Date rec'd by registrar) (b) Lester Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 1 1945, at 11 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-21 1944 to 12-1 1945, and that I last saw h. alive on 12-1 1945.

Immediate cause of death	Duration
Intestinal Obstruction	
Hypertension.	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H Edmund Kern, M.D.
Address Levindale Date signed 12/7/45

VS 186

X

634675

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13/a

✓ 634675 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1609 Aisquith St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1609 Aisquith St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Inez Bieller

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: John Bieller

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 7-[illegible]

8. AGE: Years 57 | Months 7 | Days 21 | If less than one day hr. min.

9. Birthplace West Virginia
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Wm Wall
13. Birthplace W Virginia

MOTHER
14. Maiden Name Not Known
15. Birthplace —

16 (a) Informant John A Bieller
(b) Address 1609 Aisquith St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 3 45 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Balto

18 (a) Funeral director John J Herr Son
(b) Address 3009 Kentucky Ave
(c) Thaddeus Williams, M.D.

19 (Date rec'd by registrar) 1945 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 28 1945, at 7 9 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1945 to Nov 28 1945, and that I last saw alive on Nov 28 1945

Immediate cause of death Aortic Regurgitation — Duration

Due to Hypertension

Due to Interstitial Nephritis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature M. A. Jacobs
Address 617 North St Date signed 12/3 1945

VS 150

REGARDS WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

AB-76014 G34676 BALTIMORE CITY HEALTH DEPARTMENT Registered No. G34676

CERTIFICATE OF DEATH 1937

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3yrs-3months-20days
(e) Length of stay in Baltimore (yrs., mos., or days) 4yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. ?Salvation Army
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James H. Crostic

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Separated

6 (b) Name of husband or wife Connie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 17- 1885

8. AGE: Years 60 Months 9 Days 14 If less than one day hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name C. H. Crostic Sr. (D)
13. Birthplace Va.

MOTHER
14. Maiden Name Sarah Grieves (D)
15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals(Record)
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Maury.
Location Richmond Va.

18 (a) Funeral director W. J. Jackson & Son
(b) Address Penn & Hoffman Ave. Huntington Williamsport

DEC 2 1945 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 1 1945, at 9A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-11- 1942, to 12-1- 1945, and that I last saw h im alive on 12-1- 1945.

Immediate cause of death Coronary Thrombosis

Due to Arteriosclerotic Heart Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: none

of autopsy: none

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature T. P. Jerrigan M. D.
Address Baltimore City Hall Date signed 12-1-45

X

634677 BALTIMORE CITY HEALTH DEPARTMENT 634677
CERTIFICATE OF DEATH 307
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 507 Wilson st.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dead
(e) Length of stay in Baltimore (yrs., mos., or days) 18 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 507 Wilson st. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country No

3 (a) FULL NAME Arrow C. Tibbs

3 (b) If veteran, name war: None
3 (c) Social Security Account No.:
4. Sex: Female
5. Color or race: Colored
6 (a) Single, married, widowed or divorced: Widowed
6 (b) Name of husband or wife: John
(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 10-14-1905
8. AGE: Years 40 | Months 1 mo | Days 13 | If less than one day hr. min.
9. Birthplace Middlesex Co. Va. (Town, county, and state)
10. Usual Occupation Cook
11. Industry or business Belvedere Hotel
FATHER 12. Name John Fields
13. Birthplace Va.
MOTHER 14. Maiden Name Bessie ?
15. Birthplace Va
16 (a) Informant Hilda Nutt (sister in law)
(b) Address 522 W Lanvale St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-2-45 (month) (day) (year)
(c) Cemetery or crematory Trust Baptist
Location Middlesex Co. Va
18 (a) Funeral director Charles H. Loos Sr
(b) Address 512 N. Carrollton Ave
19 (a) DEC 2 1945 (Date received by registrar) (b) Registrar Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-27- 1945, at 9P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Dissecting aneurysm of Aorta with rupture into pericardial sac.

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury:

23. Signature Benedict Skiotarelis M.D. Medical Examiner.
Date signed 11-28-45

Please write the causes of death clearly and legibly. Physicians: please write legibly, important.

634678

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

634678 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Michigan (b) County
(c) City or town Hampton Lick (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michael Horton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 5-1909

8. AGE: Years 36 | Months 1 | Days 24 | If less than one day hr. min.

9. Birthplace Chicago Ill (Town, county, and state)

10. Usual Occupation Seaman

11. Industry or business

FATHER 12. Name Steve, Horton

13. Birthplace ?

MOTHER 14. Maiden Name ?

15. Birthplace Austria

16 (a) Informant Leo Miller - Fem. Friend

(b) Address 9212 Joseph Campau Ave. Detroit

17 (a) Removal (b) Date thereof 12/1/45 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Olivet

Location Detroit Mich.

18 (a) Funeral director Wm Cox Inc

(b) Address 217 St Paul St

19 (a) [illegible] Armstrong for Williams, M.D.

DEC 2 - 1945 (Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 29 1945, at 10:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

Autopsy, Inspection or Inquiry

IMMEDIATE CAUSE OF DEATH Drowning

Skull fracture

Due to Fracture of ribs

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury Nov 29 1945 8:40 P.M.

(b) Where did injury occur? Pier I, Canton

(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? Yes

(d) Means of injury Fell from ship

23. Signature Benedict Shetarelic M.D. Medical Examiner.

Date signed 11-30-45

the causes of death clearly and legibly. ... especially important. Physicians: please write

483712 G34679

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 B

Registered No. G34679

Every item of information should be carefully supplied. Write the causes of death clearly and legibly. Direct age is especially important. Physicians: please write plainly. USE BLACK INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Perry Hall
(If outside city or town limits, write RURAL and give town)
(d) Street No. Belair Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME David Dannenfelser (David A. Dannenfelser)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Marguerite
6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) 4-11-70 1870

8. AGE: Years	Months	Days	If less than one day
75	7	20	hr. min.

9. Birthplace Md
(Town, county, and state)
10. Usual Occupation Grocer. retired
11. Industry or business

FATHER
12. Name Philip Dannenfelser.
13. Birthplace Ger.

MOTHER
14. Maiden Name Katherine Nily
15. Birthplace Ger.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 3, 1945 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore, Md.

18 (a) Funeral director Lazarus Funeral Home
(b) Address 7401 Belair Road

19 (a) 1945 (b) (Filed by registrar)

Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec - 1 - 1945 at 3.15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov - 15 1945 to Dec 1 1945 and that I last saw him alive on Dec 1 1945

Immediate cause of death Respiratory failure — Duration

Due to General Cachexia

Due to P.O. resection of colon with fecal fistula

Other Conditions Total gastrectomy
(Include pregnancy within 3 months of death)

Date of operation 11-17-45

Major findings of operation: Carcinoma of stomach

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. A. Cooley, M.D.
Address The J. Hopkins Hosp. Date signed 12-1-45

G34680 — BALTIMORE CITY HEALTH DEPARTMENT — G34680 Registered No.

AB-97457 — CERTIFICATE OF DEATH — 1945

Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 days
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 9 S. Stricker St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Doriety

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-12-4069

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 24- 1893

8. AGE: Years	Months	Days	If less than one day
52	5	0	hr. min.

9. Birthplace N.J.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name William Doriety
13. Birthplace Scotland

MOTHER
14. Maiden Name Margaret ?
15. Birthplace Ireland

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 2nd 1945 (month) (day) (year)
(c) Cemetery or crematory
Location Philpa Pa.

18 (a) Funeral director Leo D Brook
(b) Address 1701-03 N Patterson Park Ave

DEC 2 - 1945

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION AM

20. DATE OF DEATH Nov. 24 1945, at 10.30M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-24- 1945 to 11-24- 1945, and that I last saw him alive on 11-24- 1945.

Immediate cause of death	Duration
Coronary Occlusion	?
Due to Arteriosclerotic Heart Disease	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Margaret M. Davis M. D.
Address 4940 Eastern ave, Date signed 11/25/45

0 X

634681

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

634681 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days) 33 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2507 Liberty Heights. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Harry Gorelick

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Jennie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1890

8. AGE: Years	Months	Days	If less than one day
55			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Merchant
11. Industry or business

FATHER
12. Name Laba
13. Birthplace Russia

MOTHER
14. Maiden Name Orucha
15. Birthplace Russia

16 (a) Informant Jennie Gorelik
(b) Address 2507 Liberty Heights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-2-45 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Phila Rd + Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E Balto St

DEC 2 - 1945 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 30, 1945 at 8:05 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH
Gunshot wound of left chest.
Due to Hemothorax

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7:40 P.M. 11-30-45
(b) Where did injury occur? 320 N. Fremont Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Gun. place of business While at work? yes
(d) Means of injury Shot during holdup.

23. Signature Benedict Shtarkman M.D.
Medical Examiner.
Date signed 12-1-45

634682 BALTIMORE CITY HEALTH DEPARTMENT 634682
CERTIFICATE OF DEATH 137a Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13-4
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2833 Parkwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Morris Katz
3 (b) If veteran, name war —
3 (c) Social Security Account No. —
4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced. Widow
6 (b) Name of husband or wife Jennie
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1879
8. AGE: Years 66 Months Days If less than one day hr. min.
9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business

FATHER
12. Name Bene
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Hosp Record
(b) Address
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-2-45 (month) (day) (year)
(c) Cemetery or crematory Herring Run
Location Park Rd & Bowleys Lane
18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E Balto St
19 (a) 12-2-1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 1 1945, at 6:10 P M
21. I certify that death occurred on the date above stated; that I attended deceased from Nov 13 1945 to Dec 1 1945, and that I last saw him alive on Dec 1 1945.
Immediate cause of death Cardiac Failure — Duration
Due to Arteriosclerosis C.V. Renal
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation Nov 20, 1945
Major findings of operation: Benign Prostatic Hypertrophy
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature
Address Sinai Hospital Date signed Dec 1, 1945 M. D.

Howard Williams, M.D. Registrar

VS 150

634683 634683

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 72a

Registered No.

INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15d
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3510 Copley Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bess Levy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Herbert

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1906

8. AGE: Years 39 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or Business

FATHER 12. Name Samuel
13. Birthplace Russia

MOTHER 14. Maiden Name Ethel
15. Birthplace Russia

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-2-45 (month) (day) (year)

(c) Cemetery or crematory B'Nai Israel
Location Northern Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 1459 E Balto St

19 (a) (Date rec'd by registrar) (b) Huntington Williams Registrar

DEC 2 - 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 1 1945, at 7 26 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 30 1945 to Dec 1 1945. and that I last saw him alive on Dec 1 1945

Immediate cause of death: CIRCULATORY COLLAPSE — Duration 8 hrs
? WATERHOUSE - FRIEDRICHSON Syndrome

Due to: ? LUPUS ERYTHEMATOSIS DISSEMINATUS — ?

Due to:

Other Conditions: Thrombocytopenic Purpura
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: permission denied

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Laurie Duckett M.D.
Address Johns Hopkins Hospital 93B Date signed 12/3/45

634684

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 43

634684 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4343 Reisterstown Rd.
(c) Hospital or institution: 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County 3
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4343 Reisterstown Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CORA G. PRENTISS

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Charles H. Prentiss
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 2, 1878

8. AGE: Years	Months	Days	If less than one day
67	1	28	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Richard L. W. Simmons
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Mary E. Higdon
15. Birthplace Balto., Md.

16 (a) Informant Mr. Charles H. Prentiss
(b) Address 4343 Reisterstown Rd.

17 (a) Burial (b) Date thereof 12/3/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

DEC 2 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 30, 1945, at 9:55PM

21. I certify that death occurred on the date above stated; that I attended deceased from MARCH 1945 to Nov. 30 1945, and that I last saw h[illegible] alive on Nov. 25 1945.

Immediate cause of death MYCOSIS FUNGOIDES — Duration YEARS

Due to SCATTERED OVER ENTIRE BODY

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Otto Hoffman M.D.

Address 8 East Read St Date signed 12-1-45

X

634685

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1160a

634685 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 15'
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3121 Gwynns Falls Pkwy. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Mary Catherine McKee

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-29-45

8. AGE: Years | Months | Days: 2 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation infant

11. Industry or business

FATHER
12. Name William Vincent McKee
13. Birthplace Independence, Oregon

MOTHER
14. Maiden Name Mary Robertson
15. Birthplace Balto., Md.

16 (a) Informant Mr. W. V. McKee
(b) Address 3121 Gwynns Falls Pkwy.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/3/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Rest Cem.
Location La Plata, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) 1945 (Date received by registrar) (b) Irvington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-1 1945, at 7.03 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/29 1945 to 12/1 1945 and that I last saw her alive on 12/1 1945.

Immediate cause of death: Intracranial Hemorrhage — Duration: 2 days
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature I. K. Kezerian M. D.
Address Franklin Square Hosp. Date signed 12-1-45

VS 150

PRINT WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34686

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √30

G34686 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write in ink. Do not use pencil. Do not abbreviate.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hosp. 16th
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2829 Riggs Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Joseph Caton, Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-07-7931

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Cora R. Caton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4, 1891

8. AGE: Years	Months	Days	If less than one day
54	4	26	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Checker
11. Industry or business Balto. Transit Co.

FATHER
12. Name John J. Caton, Sr.
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs. Cora R. Caton
(b) Address 2829 Riggs Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/4/45 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) DEC 2 - 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 30 1945, at 1.0 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Ruptured Aneurysm of Aorta

Due to Luetic Aortitis

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Foster M.D. Medical Examiner.
Date signed 12-1-45

VS 151

634687

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

634687
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison + Eager
(c) Hospital or institution:
Maryland General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Va (b) County
(c) City or town Saluda
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Eunice Payne Barnes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex Female | 5 Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Stanley L Barnes

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 19 1913

8. AGE: Years 32 | Months 5 | Days 12 | If less than one day hr. min.

9. Birthplace Middlesex Co. Virginia
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John C. Payne
13. Birthplace Middlesex Co. Va.

MOTHER
14. Maiden Name Adel Emma Payne
15. Birthplace Middlesex Co Va.

16 (a) Informant John C. Payne
(b) Address Virginia

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 5, 1945 (month) (day) (year)
(c) Cemetery or crematory Lower Church Cemetery
Location Middlesex Co. Va.

18 (a) Funeral director Milligan J Dickens + Sons
(b) Address Bath + Broadway Fremont Ave

19 (a) DEC 2 1945 (Date received by registrar) (b) Registrar

Howard Lee Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 2 1945, at 2 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-22 1945, to 12-2 1945, and that I last saw her alive on 12-1 1945.

Immediate cause of death Tuberculous meningitis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. M. Candiell M. D.
Address Maryland General Hosp. Date signed 12-3-45

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634688 634688

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address St. Josephs Hosp
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3633 Puget St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mary Green Jenkins

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Fem	Cl.	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/28/1914

8. AGE: Years	Months	Days	If less than one day
30	11	1	hr. min.

9. Birthplace BALTIMORE (Town, county, and state)
10. Usual Occupation HOUSE WIFE
11. Industry or business

FATHER	12. Name Harry Green
	13. Birthplace Md
MOTHER	14. Maiden Name Mary Owens
	15. Birthplace Md

16 (a) Informant Daisey Cook
(b) Address 1209 Myrtle AVE
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 3 45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location R. A. Co
18 (a) Funeral director Raymer Sanders
(b) Address 1412 E. Preston St
1945 Registered by Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov-29 1945, at 12 55 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 27 1945 to Nov 29 1945 and that I last saw her alive on Nov. 29 1945

Immediate cause of death	Duration
Chronic Peritonitis — Atelectasis	
Due to Parametritis	
Due to Carcinoma of cervix	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Atelectasis, Chronic peritonitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature John T. Everett M.D.
Address St Joseph's Date signed 11/29/45

VS 150

634689

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

634689 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Little Sisters of the Poor
(b) Street address 1200 Valley St.,
(c) Hospital or institution:
Home for Aged Poor 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 Months
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eberhard Rausch

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. W.

6 (b) Name of husband or wife Maria Schleich
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE 73 Years	Months	Days	If less than one day hr.	min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Rausch
13. Birthplace

MOTHER
14. Maiden Name Maria —
15. Birthplace

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley St.

17 (a) Burial (b) Date thereof Dec. 3 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 94 Greenmount Ave

DEC 2 - 1945
(Date rec'd by Registrar)

(b) Huntington Williams M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov-30- 1945, at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 29- 1945 to Nov-30- 1945 and that I last saw him alive on Nov 29- 1945

Immediate cause of death	Duration
Cerebral Hemorrhage	1 day
Due to Arterio-Sclerosis	5 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. Gill Hall M. D.
Address 1631 E North Ave Date signed 12/1/45

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634690

BALTIMORE CITY HEALTH DEPARTMENT ✓ 634690 Registered No.

CERTIFICATE OF DEATH 15-9

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1day
(e) Length of stay in Baltimore (yrs., mos., or days) 1day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 834 Hillman Court (2) (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Baby Girl Handerhan

3 (b) If veteran, name war: No
3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-29-45

8. AGE: Years | Months | Days | If less than one day: 12 hr. 5 min.

9. Birthplace Franklin Sq. Hosp; Baltimore, Md (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Clifford Handerhan
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Eileen Handerhan
15. Birthplace New York

16 (a) Informant Mrs. Eileen Handerhan
(b) Address 834 Hillman Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-3-45 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem.
Location City

18 (a) Funeral director [signature]
(b) Address

19 (a) 12 1945 (Date rec'd by registrar) (b) [signature] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 30 1945, at 12:01 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-29 1945, to 11-30 1945, and that I last saw her alive on 11-30 1945.

Immediate cause of death: Respiratory Failure — Duration: 1day

Due to: Prematurity - 28 months

Due to:

Other Conditions
(include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. K. Kyzman M. D.
Address Franklin Sq. Hosp Date signed 11-30-45

PRINT WITH PENCIL, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34691

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92B

G34691 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1819 Riggs ave
(c) Hospital or institution:

16

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1819 Riggs ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helen Gertrude Meiser

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed or divorced
F	W	Widowed

6 (b) Name of husband or wife Herman Meiser
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 19, 1877

8. AGE: Years	Months	Days	If less than one day
68	10	10	hr. min.

9. Birthplace Baltimore, Md.
(Town, county and state)
10. Usual Occupation Home Duties
11. Industry or business

FATHER
12. Name George Hester
13. Birthplace Baltimore

MOTHER
14. Maiden Name Caroline Kraft
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Marie C. Thieme
(b) Address 2022 Reynolds ave

17 (a) Burial (b) Date thereof Dec. 3, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore

18 (a) Funeral director Frederick A. Dole
(b) Address 1210 W. Fayette St. Baltimore 21

19 (a) (b)
(Date rec'd by registrar) Registrar

1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 29 1945, at 11:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 4 1944 to Nov 29 1945 and that I last saw h[illegible] alive on 11/28 1945

Immediate cause of death	Duration
Cardiac Decompensation	1 month
Due to Mitral Insufficiency	
Due to	
Other Conditions Hypertension	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thos A Dolan M. D.
Address 2145 W Balto St Date signed

VS 150

X

G34692

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G34692 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution:
Maryland Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1800 Bolton St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Carl H. Jung

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 20, 1870

8. AGE: Years	Months	Days	If less than one day
76	7	9	hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER 12. Name Joseph Jung

13. Birthplace Germany

MOTHER 14. Maiden Name —

15. Birthplace

16 (a) Informant Jacob Arbogast

(b) Address 1800 Bolton St

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof Dec 3/45 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location 3801 Frederick Ave

18 (a) Funeral director John A. Mitchell & Sons

(b) Address 1900 Eutaw Place

19 (a) Date rec'd by registrar (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 2, 1945, at 12:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 17 1945, to Dec 2 1945, and that I last saw h[illegible] alive on Dec 1 1945

Immediate cause of death	Duration
Cardiac Failure	
Due to HC VD	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. M. Randall M. D.

Address Md Gen Hosp Date signed 12-2-45

X

Any item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634693 BALTIMORE CITY HEALTH DEPARTMENT 634693
CERTIFICATE OF DEATH 1812 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4702 Harford Ave.
(c) Hospital or institution: 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1410 Fulton Ave. (N.) (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie Murphy

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Samuel Murphy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 2, 1871

8. AGE: Years	Months	Days	If less than one day
74	1	27	hr. min.

9. Birthplace Lonaconing, Md. (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name Wilhelmina Jones
15. Birthplace Lonaconing, Md.

16 (a) Informant Edward J. Morningstar
(b) Address 2603 Elsinor Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/3/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Ave.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 29th 1945, at 1245 M A.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1- 1944 to Nov 30 1945, and that I last saw h[er] alive on Nov 29 1945

	Duration
Immediate cause of death Uraemia	
Coma	24 hrs
Due to arterio sclerosis	
✓ chronic nephritis	2 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. J. McDermott M. D.
Address 1136 Poplar Grove St. Date signed

Registered by Hunterton Williams, M.D. Registrar

X M.J. McDERMOTT

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G34694

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 15729

Registered No. G34694

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene
(c) Hospital or institution: Univ. Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Washington
(c) City or town Hagerstown Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1078 Columbia Rd
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME RICHARD MATTHEW KNOX

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11 | 28 | 45

8. AGE: Years | Months | Days: 5 | If less than one day: — hr. — min.

9. Birthplace Baltimore, Balt. Co. Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Clarence Matthew Knox
13. Birthplace Carroll Co. Md.

MOTHER
14. Maiden Name Anna Madeline Klonis
15. Birthplace Carroll Co. Md.

16 (a) Informant Mother -
(b) Address Same.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Dec 7 45 (month) (day) (year)
(c) Cemetery or crematory Bridges
Location Westminster Md.

18 (a) Funeral director J. F. Reese
(b) Address Westminster Md.

(c) Date received by registrar DEC 3 1945 (Signature of Registrar) Tunatia A. Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 December 1945, at 405 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-29 1945 to 12-2 1945, and that I last saw h/ M alive on 12-2 1945

Immediate cause of death: Unknown - Probably multiple congenital anomalies — Duration

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address Hagerstown Md. Date signed 12-2-45 M.D.

634695

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 99 ✓

634695 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette Ave & John St.
(c) Hospital or institution Women's Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 32 days 1 mo
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1701 Bolton Street
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Roberta Veal

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Joseph E. Veal
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/8/65

8. AGE: Years	Months	Days	If less than one day
80	8 9	24	hr. min.

9. Birthplace New Kent Co. Virginia
(Town, county, and State)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name John P Pierce
13. Birthplace Charles City, Virginia

MOTHER
14. Maiden Name Mary W. Christian
15. Birthplace New Kent Co Virginia

16 (a) Informant Miss M. Hyde
(b) Address 2601 Talbot Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/4/45 (month) (day) (year)
(c) Cemetery or crematory Myrtle Hill Cem.
Location Rome Ga.

18 (a) Funeral director Earl L. Hess
(b) Address 7 N. Light St.

DEC 3 - 1945 (Date received by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/2/1945 at 9:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/2/1945 to 12/2/1945 and that I last saw her alive on 12/2/1945

Immediate cause of death ~~Coronary thrombosis~~ myocardial infarction
Duration 32 days

Due to Arteriosclerotic Cardiovascular disease

Due to

Other Conditions Mesenteric thrombosis, operative removal of sc. colon
(Include pregnancy within 3 months of death) cancer

Date of operation 11/29/45

Major findings of operation: Mesenteric Thrombosis, Rt. Colic Artery

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Richard Compton
Address Hospital for Women Date signed 12/3/45 M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

34696

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. 34696

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital, Balto., Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) unknown

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Randallstown
(If outside city or town limits, write RURAL and give town)
(d) Street No. None
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Gilbert Carroll

3 (b) If veteran, name war --

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife Sarah Clay
6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) May 24, 1897

8. AGE: Years	Months	Days	If less than one day
48	6	24	....hr. ....min.

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation mailclerk
11. Industry or business Post Office Employee

FATHER
12. Name John C. Carroll
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Sarah Barley
15. Birthplace Parkton, Maryland

16 (a) Informant Records
(b) Address U. S. Marine Hospital, Balto. Md.

17 (a) Burial (b) Date thereof 12/4/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olive
Location Roslyn Md

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul st

DEC 3 - 1945 (b) Huntington Williams, M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 1 1945 at 8:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 28 1945, to Dec. 1 1945, and that I last saw him alive on Dec. 1 1945

Immediate cause of death	Duration
Hemorrhage, left cerebellum.	few days
Due to Nephrosclerosis with arterial hypertension and cardiac hypertrophy.	unknown
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address U. S. Marine Hospital Date signed Dec. 1, 45
Baltimore, Maryland

VS 150

Type or print the causes of death clearly and legibly.

634697

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a

Registered No. 634697

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 624 E. 36th Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) 4 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County BALTO.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 624 E 36d street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fred J. Willette

3 (b) If veteran, name war W.W.# 2

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: TENIE WILLETTE

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOV. 15 1892

8. AGE: Years 53 | Months 0 | Days 15 | If less than one day ..... hr. ..... min.

9. Birthplace MICHIGAN (Town, county, and state)

10. Usual Occupation SOLDIER

11. Industry or business US. ARMY

FATHER
12. Name FREDERICK WILLETTE
13. Birthplace MICH.

MOTHER
14. Maiden Name MARY FOGERTY
15. Birthplace MICH?

16 (a) Informant TENIE WILLETTE (WIFE)
(b) Address 624 E. 36th. ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof DEC. 6/45 (month) (day) (year)
(c) Cemetery or crematory PASSCHRISTIAN CEM.
Location PASSCHRISTIAN MISS.

18 (a) Funeral director Leilly & Zeiler Inc.
(b) Address 403 S. WOLFE ST.

19 (a) DEC 3 1945 (Date Filed) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 30, 1945, at 11 30 P.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Rio death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to Atherosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Stetarelli M.D. Medical Examiner.
Date signed 12-1-45.

X

634698

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH / 3 B

✓ 634698 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Gordon
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3144 Dillon st (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Theresa Wisley

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Edward Wisley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) aug 23 1887

8. AGE: Years 58 | Months 3 | Days 8 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation House Wife
11. Industry or business at home

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace unknown.

16 (a) Informant Edward Wisley (Husb)
(b) Address 3144 Dillon st.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 4/45 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location German Hill Road

18 (a) Funeral director Lilly & Zeiler Inc.
(b) Address 403 S Wolfe st.

DEC 3 1945 (Date received by local registrar) (b) Huntington Williamsville P

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December / 1945, at 2.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 20 1945, to Dec / 1945, and that I last saw h[illegible] alive on Dec / 1945.

Immediate cause of death: Cardiac failure — Duration

Due to: Chronic hypertension

Due to:

Other Conditions: Pulmonary TBC

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. M. Sacred M. D.
Address Maryland General Hosp. Date signed 12-1-45

93D

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634699

AB-97502

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

931

Registered No. 634699

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 6-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 15 N. Wolfe St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie Stein

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 20- 1898

8. AGE: Years	Months	Days	If less than one day
47	3	11	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business at home.

FATHER
12. Name Frederick Stein
13. Birthplace Md.

MOTHER
14. Maiden Name Anna Snyder
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 5/45 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern ave Expt

18 (a) Funeral director Leilly & Zeiler inc.
(b) Address 403 S. Wolfe st.

19 (a) [illegible] (b) Huntington Williams, M.D.

DEC 3 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 1- 1945, at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-26 1945 to 12-1 1945, and that I last saw her alive on 12-1 1945.

Immediate cause of death	Duration
Cardiac Failure	3 days?
Due to Hypertension Cardiac vascular disease	5
Due to	
Other Conditions Cerebral Hemorrhage, type Hemiparesis rt. upheld	5 days

(Include pregnancy within 3 months of death)
Date of operation Hemiparesis
Major findings of operation:
of autopsy: Partial

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. Woodward M. D.
Address Baltimore City Hospital Date signed 12-2-45

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34700

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G34700 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 812 N Fremont ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Keller

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	negro	widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-12-74

8. AGE: Years	Months	Days	If less than one day
71	3	19	hr. min.

9. Birthplace Frederick, Md (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name George Smith
13. Birthplace Md

MOTHER
14. Maiden Name Family Canned
15. Birthplace Md

16 (a) Informant Mrs Anita K. Henson
(b) Address 814 N. Fremont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-4-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md

18 (a) Funeral director Jesse W. Redden
(b) Address 434 W. Biddle St

19 (a) Filed by Registrar Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-1 1945 at 11:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-25 1945 to 12-1 1945 and that I last saw her alive on 12-1 1945

Immediate cause of death Lobar pneumonia — Duration one week

Due to

Due to

Other Conditions Hypertensive cardiovascular-renal disease
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. R. Campbell M. D.
Address 718 Dolphin St. Date signed 12-3-45

correct age is especially important. Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied.

634701

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

198

634701 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 954 Forrest St
(c) Hospital or institution Maryland Penitentiary
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Essex
(If outside city or town limits, write RURAL and give town)
(d) Street No. 15 Helena Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Donald Herbert Brooks

3 (b) If veteran, name war: World War II

3 (c) Social Security Account No. 35-730-55A

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Wilhelmina Brooks

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Jan. 18, 1913

8. AGE: Years 32 | Months 10 | Days 12 | If less than one day: hr. min.

9. Birthplace Mt. Winans, Md (Town, county, and state)

10. Usual Occupation Chauffeur

11. Industry or business

FATHER 12. Name Samuel Brooks

13. Birthplace Virginia

MOTHER 14. Maiden Name Kathryn Riser

15. Birthplace Martinsburg, West Va

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof 12 3 45 (month) (day) (year)

(c) Cemetery or crematory Sacred Heart

Location Jerman Hill Rd

18 (a) Funeral director J. H. Apple Sons

(b) Address 1318 Light St

19 (a) Dec 3 1945 (b) (Registered by Health Dept.) Registrar

VS 150

transcription Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 30 1945, at 7:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 9 1944, to Nov. 30 1945, and that I last saw him alive on Nov. 30 1945.

	Duration
Immediate cause of death: Dislocation of 5th Cervical vertebra	
Due to: Execution by hanging	
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr C. F. Harris, M. D.

Address Medical Arts Bldg. Date signed 11-30-45

X

G34703

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93D

G34703 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2212 West Lanvale
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2212 West Lanvale (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rebecca Levins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Hetzel Levins

6 (c) If above, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years 62 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Israel —
13. Birthplace Russia

MOTHER
14. Maiden Name Roach —
15. Birthplace Russia

16 (a) Informant Charles Levine
(b) Address 2309 N. Pulaski St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-3-45 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location

18 (a) Funeral director Jack Levine Inc
(b) Address 1439 E. Baltimore St

19 (a) (Date rec'd by Registrar) DEC 3 - 1945 (b) Huntingtown Williams, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/2/45 19... at 3:15 P.M.

21. I certify that I took charge of the remains described above, held an Inspection of Same (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John L. Wairs, M.D. Medical Examiner.
Date signed 12/2/45

634703

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13/a

634703 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2476 Shirley Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3514 Holmes Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Flax

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F.

5. Color or race W.

6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Manuel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1865

8. AGE: Years 80 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Morris Flax
(b) Address 3513 Liberty Hts

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-3-45 (month) (day) (year)
(c) Cemetery or crematory Herring Run
Location Balto. Co. Rt Bowleys Lane

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Balto. St

19 (a) DEC 3 - 1945 (Date received by registrar) (b) [signature] Registrar

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-2-45 19 , at 2.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/15/45 19 to 12/2/45 19 , and that I last saw h[illegible] alive on 12/1/45 .

Immediate cause of death Cardiac Failure (due to)
Due to Arterio Sclerosis
Due to Hypertension 2 yrs
Other Conditions Bright's Disease 6 yrs

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature [signature]
Address 2040 Eutaw Date signed 12/3-45

G34704 .

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46

G34704 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St. & Rutland Ave.
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1812 Walbrook Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fannie Furman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Jacob Furman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1873

8. AGE: Years 72 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Alex Cohen
13. Birthplace Russia

MOTHER
14. Maiden Name Minnie —
15. Birthplace Russia

16 (a) Informant Rosa Furman
(b) Address 1812 Walbrook Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-3-45 (month) (day) (year)
(c) Cemetery or crematory Druedale
Location

18 (a) Funeral director Jack Levin Inc.
(b) Address 1439 E. Baltimore St

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

DEC 3 - [illegible] for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 3, 1945, at 12 30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 2, 1945 to Dec. 3, 1945, and that I last saw her alive on Dec. 3, 1945

Immediate cause of death Cardiac failure — Duration

Due to Bronchopneumonia

Due to

Other Conditions Ca of head of pancreas & metastases

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert J. Weiss

Address Sinai Hospital Date signed 12/3/45 M. D.

G34705 Locher

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131A

G34705 Registered No.

Please write plainly, with unfading ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1509 Ogden St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1509 Ogden St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michael Lachler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife Barbara Rein Locher
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 14, 1860

8. AGE: Years	Months	Days	If less than one day
85	9	16	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Laborer Retired
11. Industry or business

FATHER
12. Name Joseph Locher
13. Birthplace Germany

MOTHER
14. Maiden Name Cynthia Unknown
15. Birthplace Germany

16 (a) Informant John Locher Son
(b) Address 2941 S. Bradley Ave Balto

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 4 1945 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem
Location Baltimore

18 (a) Funeral director Thomas V. Flemming
(b) Address 1426 Eutaw St

DEC 3 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 30 1945, at 8:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1945 to Nov 30 1945, and that I last saw h alive on Nov 30 1945

Immediate cause of death: Acute Dilation of Heart — Duration 2 hrs
Due to Senility
Due to Arteriosclerosis
Other Conditions Nephritis
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. E. Campbell M. D.
Address 1644 Harlem Ave Date signed 12/3/45

VS 150

G34706
480529.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46B

G34706
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N. Y. (b) County
(c) City or town New York. (If outside city or town limits, write RURAL and give town)
(d) Street No. 34 Front St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Randahl.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Widower.
6 (c) If alive, give age 67 years
7. Birth date of deceased (mo., day, yr.) 1-7-69
8. AGE: Years 76 | Months 10 | Days 16 | If less than one day hr. min.
9. Birthplace Den. (Town, county, and state)
10. Usual Occupation Emporter.
11. Industry or business

FATHER
12. Name Carl Randahl
13. Birthplace Denmark.

MOTHER
14. Maiden Name Elizabeth Cufferman.
15. Birthplace Den.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 13/45 (month) (day) (year)
(c) Cemetery or crematory, Manilla Location Philippine Islands
18 (a) Funeral director Julio C. Mitchell & Sons
(b) Address 1918 Eutaw Place
19 (a) (b)
DEC 3 - 1945 Huntington Hollidaysburg, Pa. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 23 1945, at 2.10 M
21. I certify that death occurred on the date above stated; that I attended deceased from Sept - 17 1945 to Nov - 23 1945 and that I last saw him alive on Nov - 23 1945.

Immediate cause of death	Duration
Respiratory failure	
Due to shock and general Cachexia	
Due to Carcinomatosis	
Other Conditions G.U. gastrectomy	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature W. P. Mueller M. D.
Address The Johns Hopkins Hospital Date signed 12-3-45

G34707

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47

Registered No. G34707

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Aves
(c) Hospital or institution St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 yrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balt. (If outside city or town limits, write RURAL and give town)
(d) Street No. 205 Pontiac Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Walter Crumblies
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 [illegible], married, widowed, or divorced 13-12-8006

6 (b) Name of husband or wife Margaret
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1901

8. AGE: Years 44 | Months | Days | If less than one day hr. min.

9. Birthplace Kansas City Mo. (Town, county, and state)

10. Usual Occupation Garage owner
11. Industry or business

FATHER 12. Name James F. Crumblies
13. Birthplace Mo.

MOTHER 14. Maiden Name Laura Pitts
15. Birthplace Mo.

16 (a) Informant Mrs Margaret Crumblies
(b) Address 205 Pontiac Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/5/45 (month) (day) (year)
(c) Cemetery or crematory Holy Cross Brooklyn
Location Gov Ritchie Highway

18 (a) Funeral director Milton Schilling
(b) Address 3914 S. Hanover St

19 (a) [illegible] (Date rec'd by Reg'r) (b) Huntington Williams M.D. Registrar

DEC 3 - 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-1 1945, at 4 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-30 1945 to 12-1 1945 and that I last saw h/her alive on 12-1 1945

Immediate cause of death Cardio-Respiratory Failure — Duration
Para. Uremia
Due to Ca Lung c Metastasis
Due to
Other Conditions Generalized debility + malnutrition
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: 12-1-45

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. McFadden M. D.
Address St Agnes Hosp. Date signed 12-1-45

X

634708

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

634703 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St. & Rutland Ave.
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County Lancaster
(c) City or town 142 S. St. Joseph St.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Samuel Kautz

3 (b) If veteran, name war

3 (c) Social Security Account No. [redacted]

4. Sex M

5. Color or race W.

6 (a) Single, married, widowed, or divorced Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 20 1864

8. AGE: Years 81 Months 6 Days 13 If less than one day hr. min.

9. Birthplace Lancaster Pa.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joseph Kautz
13. Birthplace Pa

MOTHER
14. Maiden Name Rachel Rhoades
15. Birthplace

16 (a) Informant Sinai
(b) Address

17 (a) Burial (Burial, cremation, removal) (b) Date thereof 12/5/45 (month) (day) (year)
(c) Cemetery or crematory Cedar Lawn
Location Lancaster Pa.

18 (a) Funeral director Wm. J. Buchmeyer & Son
(b) Address 402 E. Orange

19 (a) Date received by registrar DEC 6 1945

Registrar for Williams

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH December 2, 1945 at 11:58 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 2, 1945 to Dec. 2, 1945 and that I last saw him alive on Dec. 2, 1945.

Immediate cause of death Bronchopneumonia — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of ~~operation~~ autopsy: Bronchopn. RUL & RLL & marked congestion

of autopsy: & emphysema

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert J. Weiss M.D.

Address Sinai Hospital Date signed 12/3/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634709

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

634709 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1 Wellens v Caton Ues
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) Same (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 134 S. Morley St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Editta W Goodwin

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband ~~of wife~~ Albert Harris Goodwin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 26-187[illegible]

8. AGE: Years	Months	Days	If less than one day
69	9	6	hr. min.

9. Birthplace Baltimore, (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name William Manly
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Rebecca Moffett
15. Birthplace Baltimore Md

16 (a) Informant Mrs Harris Goodwin
(b) Address 134 S. Morley St

17 (a) Burial (b) Date thereof Dec 6-1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Roads

18 (a) Funeral director W. Frazier Sons
(b) Address North & Fremont Ave

19 (a) (Date rec'd by Registrar) (b) Registrar
DEC 3 - 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-2 1945, at 8:55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-30 1945 to 12-2 1945, and that I last saw h[illegible] alive on 12-2 1945

Immediate cause of death	Duration
(a) Cardiac Resp failure	
Due to Accident accident	
Due to Hypostasis	
Other Conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Elijah Rawlk Jr M. D.
Address St Agnes Hosp Date signed 12/2/45

Huntington Williams, MD

83a

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly.

G34710 — BALTIMORE CITY HEALTH DEPARTMENT — G34710

CERTIFICATE OF DEATH

94Q

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Penna (b) County
(c) City or town Baltimore City Phila.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5242 Pentridge Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William H Osborne

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed~~, or ~~divorced~~
M	W	married

6 (b) Name of husband or wife Helen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 31 1880

8. AGE: Years	Months	Days	If less than one day
65 65	4	1	hr. min.

9. Birthplace
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Mrs. Helen Osborne
(b) Address 5242 Pentridge Ave Phila Pa

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 5 45
(month) (day) (year)

(c) Cemetery or crematory
Location Philadelphia Pa

18 (a) Funeral director Wm J Heffner & Son
(b) Address North & Penna Ave

19 (a) (Date received by registrar) 1945 (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/1 1945, at 6 50 P M

21. I certify that I took charge of the remains described above, held an Inspection-Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

Signature D.F. Gubinski M.D.
Medical Examiner.
Date signed 12/2/45

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34711 ✓ G34711

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1312 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2731 Parkwood Av
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 4
(e) Length of stay in Baltimore (yrs., mos., or days) 79 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2731 Parkwood Av (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Emma Christina Cragg.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife John Boose Cragg

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 29 1865

8. AGE: Years 79 | Months 11 | Days 2 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER
12. Name Everhart Wiesner
13. Birthplace Germany

MOTHER
14. Maiden Name Virginia Lessner
15. Birthplace Germany

16 (a) Informant James P Cragg
(b) Address 2731 Parkwood Av

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/5/45 (month) (day) (year)
(c) Cemetery or crematory London P/C
Location Balto - Md

18 (a) Funeral director Wm J. Ludwig & Son
(b) Address North & Pine Ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

DEC 3 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 1 1945, at 7:45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 29 1945 to Dec 1 1945 and that I last saw h alive on Dec 1 1945

Immediate cause of death

Due to Chr. Myocarditis — Duration 1940

Due to Chr. Interstitial nephritis — 1940

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James Brown M. D.
Address 1663 W North Ave Date signed 12/5/45

X

G34712

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G34712

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3529 Elmley Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3529 Elmley Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hattie J.Eagleston

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Wm.I.Eagleston
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb.11.1878

8. AGE: Years	Months	Days	If less than one day
67	9	21 19	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Wm.C.Stallings
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Sophia Lucas
15. Birthplace Balto. Md.

16 (a) Informant Mr.Harry W.Harp Jr.
(b) Address 3529 Elmley Ave.

17 (a) Burial (b) Date thereof Dec.3,1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Balto. Md.

18 (a) Funeral director Philip Stewart Sons
(b) Address 2024 Orleans St.

19 (a) Date received by registrar DEC 5 1945 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov.30/45 19 , at 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1944 to Nov 30 45 and that I last saw h[illegible] alive on Nov 30 1945

Immediate cause of death Hypostatic Pneumonia — Duration 11-27-45

Due to Ch. Myocarditis — 10/1/1944

Due to Diabetes Mellitus — 1938

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William R. Daniels M. D.
Address 801 N Kenwood Ave Date signed 12/7/45

GB47873 — G34713

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937 ✓ Registered No. G34713

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 406 Ostend St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Andrew Bailey (Gunter)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 13, 1884

8. AGE: Years	Months	Days	If less than one day
61	3	17	hr. min.

9. Birthplace Va. Accomac County
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Lewis Gunter
13. Birthplace Accomac Co., Va.

MOTHER
14. Maiden Name Mary Bailey (Mattie)
15. Birthplace Accomac County, Va

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave

17 (a) Burial (b) Date thereof Dec. 4, '45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Hattie R. Williams
(b) Address 322 N. Schroeder St
(b) (Name of cemetery or crematory) Hattie R. Williams, Mgr.

DEC 3 - 1945

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 30 1945, at 12:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 19 1945 to Nov. 30 1945, and that I last saw h. in alive on Nov. 30 1945.

Immediate cause of death CARDIAC Failure — Duration

Due to Hypertensive Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: none

of autopsy: Enlarged Heart, Pulmonary stasis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature T. P. Jernigan
Address Baltimore City Hosp. Date signed 11-30-45 M. D.

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34714

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1382

Registered No. G34714

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 205 Myrtle Ave,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 205 Myrtle Ave,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Augusta Barnes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 23, 1898

8. AGE: Years 47 | Months 2 | Days 6 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Samuel Palmer.
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Augusta Jones
15. Birthplace Baltimore Md.

16 (a) Informant James E. Barnes (Son)
(b) Address 205 Myrtle Ave.

17 (a) Burial (b) Date thereof Dec. 3 '45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Zion
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St
Huntington Williams, Mgr.

19 (a) DEC 3 - 1945 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/29 1945 at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-10 1945 to 11/29 1945.
and that I last saw h[illegible] alive on 11-28 1945

Immediate cause of death
Pulmonary Athesis
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration
3 mo

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature B. N. Hazlett M.D.
Address 1728 Pa Ave Date signed 12/3/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G34715

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 518

G34715 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 - Division St
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 weeks
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 813 - N - Mount St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Marshall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Negro

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Betty Marshall

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 15, 1890

8. AGE: Years 55 | Months 9 | Days 13 | If less than one day hr. min.

9. Birthplace Petersburg, Va (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Caisa Marshall
13. Birthplace Virginia

MOTHER
14. Maiden Name Emma Marshall
15. Birthplace Virginia

16 (a) Informant Betty Marshall
(b) Address 813 N - Mount St.

17 (a) [redacted] (Burial, cremation, or removal) (b) Date thereof Dec 3, 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R. William
(b) Address 322 N. Schroeder St.
(c) DEC 3 1945 (Date rec'd by registrar) Hunting for Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/28 1945, at 5:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/11 1945 to 11/28 1945, and that I last saw h[illegible] alive on 11/28 1945.

Immediate cause of death Carcinomatosis Peritonei

Due to Intussusception of Jejunum

Due to Carcinoma

Other Conditions Metastatic Carcinoma

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: 11/29/45

Duration
over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [redacted] M.D.

Address Provident Hospital Date signed 11/29/45

G34716

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 162B

G34716 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 W. Cold Spring Lane
(c) Hospital or institution: Elkins Cold Spring Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2101 Coldspring Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Howe

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, (widowed) or divorced.
M	W	

6 (b) Name of husband or wife Frances Howe
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 16, 1861

8. AGE: Years	Months	Days	If less than one day
84	5	14	hr. min.

9. Birthplace England (Town, county, and state)
10. Usual Occupation Chef
11. Industry or business Retired

FATHER
12. Name Unknown
13. Birthplace England

MOTHER
14. Maiden Name Unknown
15. Birthplace England

16 (a) Informant Bernard Howe (Son)
(b) Address 132 E Montgomery St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 3, 1945 (month) (day) (year)
(c) Cemetery or crematory Carkwood
Location Baltimore, Md.

18 (a) Funeral director Durward D. Covington
(b) Address 2600 W 20th St

19 DEC 3 - 1945 (Date rec'd by registrar) (c) Huntington Williams Mortuary

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 30 1945, at 3 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 21 1942 to Nov. 30 1945, and that I last saw h alive on Nov. 30 1945.

Immediate cause of death Senility — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. H. Cutterman
Address 7324 Reisterstown Rd Date signed M 12 D 1/45

VS 150

G34717

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G34717

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 70

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Esplanade Apts. Eutaw Place & Brookline (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Milton D. Greenbaum

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mrs. Milton D Greenbaum
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 18, 1875

8. AGE: Years	Months	Days	If less than one day
70	7	25	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Lawyer
11. Industry or business

FATHER
12. Name Daniel Greenbaum
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Frances Rosenbaum
15. Birthplace Pennsylvania

16 (a) Informant Mrs. M. S. Greenbaum
(b) Address Esplanade Apt.

17 (a) Burial (b) Date thereof 12/4/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery Bals. Hebrew
Location Bals. Md.

18 (a) Funeral director Edward Sonnborn & Son
(b) Address 1902 Eutaw Place

DEC 3 - 1945

(a) (b) Huntington Williams, M.D.
(State registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 3 1945, at 7:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 30 1945 to Dec. 3 1945, and that I last saw him alive on Dec. 2 1945.

Immediate cause of death Acute pulmonary edema

Due to Hypertensive cardio-vascular disease

Due to

Other Conditions Bilateral inguinal hernias

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

Duration
#4

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Frank Supplee, III M. D.
Address Union Memorial Hospital Date signed 12-3-45

X

G34718 G34718

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2416 W. Rogers Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2416 W. Rogers Ave. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME ADDIE DANNENBERG.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 20, 1879.

8. AGE: Years	Months	Days	If less than one day
66	2	12	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Philip Dannenberg,
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Lina Rosenheim,
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Edna Sussman,
(b) Address 2416 W. Rogers Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12.4.45. (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location Balto. Md.

18 (a) Funeral director Harris Sonneborn & Son
(b) Address 1902 Eutaw Place.

19 DEC 3 1945 Date rec'd by city or county Huntington Williams, M.D. Registrar

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 2, 1945, at 9 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1942 to Dec 2 1945. and that I last saw h e alive on Dec 2 1945.

	Duration
Immediate cause of death Broncho-pneumonia	3 days
Due to Exfoliative dermatitis	8 months
Due to	
Other Conditions Arteria-sclerosis + hypertension (Include pregnancy within 3 months of death)	10 years

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jacob Cohen M. D.
Address 1804 Eutaw Place Date signed 12/7/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634719

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 634719

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 84 Pontiac St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 84 Pontiac St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ernestine W. Dawson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Wm P. Dawson

6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) March 27, 1861

8. AGE: Years 84 | Months 8 | Days 3 | If less than one day ... hr. ... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

MOTHER / FATHER

12. Name George C. Demme

13. Birthplace Germany

14. Maiden Name Martha Pabst

15. Birthplace Germany

16 (a) Informant J. Edward Dawson

(b) Address 523 Maude Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/3/45 (month) (day) (year)

(c) Cemetery or crematory London Park

Location Frederick Ave

18 (a) Funeral director John F. Kenny Inc

(b) Address 715 Light St.

19 (a) [illegible] Registrar

DEC 3 1945

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 30 1945, at 6:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan - 19 1939 to Nov 30 1945, and that I last saw h.e.r alive on Oct. 10 1945.

Immediate cause of death	Duration
Acute Coronary Occlusion	1/2 hr.
Due to	
Due to Generalized - Arterio-Sclerosis	Chronic
Other Conditions Pernicious Anemia	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Lutin M.D.

Address 320 Patapsco Ave Date signed 12/1/45

G34720

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G34720 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2817 HUNTINGDON AVE
(c) Hospital or institution: NONE
(d) Length of stay in hospital or inst. (yrs., mos., or days) NONE
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND, County
(c) City or town BALTIMORE CITY.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2817 HUNTINGDON AVE.
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME MARIE STELLA ALTHOFF.

3 (b) If veteran, name war ******
3 (c) Social Security Account No. *****

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife John P.Althoff
6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) May 11-1872

8. AGE: Years	Months	Days	If less than one day
73	6	20	..... hr. ..... min.

9. Birthplace Penna. (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Jacob G.Troxel
13. Birthplace Penna.

MOTHER
14. Maiden Name Ann Wivell
15. Birthplace Penna.

16 (a) Informant John P.Althoff
(b) Address 2817 Huntingdon Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec.5-45 (month) (day) (year)
(c) Cemetery Mt.St.Mary's
Location Emmitsburg,Md.

18 (a) Funeral director Chas. F. Evans & Son
(b) Address 118 W Mt Royal Avenue

19 (a) Filed by (b) Signature of local registrar Hunting Town Williamsport

DEC 3-1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH DECEMBER 1 1945, at 10.A.M

21. I certify that death occurred on the date above stated; that I attended deceased from NOV 23 1945 to DEC 1 1945 and that I last saw her alive on DEC 1 1945.

Immediate cause of death	Duration
INFLUENZAE BRONCHITIS.NOV23	1945.
Due to CHRONIC MYOCARDIAL DEGENERATION	1944.
Due to ARTERIOR SCLEROSIS	1944.
Other Conditions	

(Include pregnancy within three months of death)
Date of operation NONE
Major findings of operation: NONE
of autopsy: NONE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chas. F. Evans
Address 3023 ST PAUL STREET Date signed DECEMBER 1 1945

634721

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945D

634724 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 304 EAST 31st STREET.
(c) Hospital or institution: NONE
(d) Length of stay in hospital or inst. (yrs., mos., or days) NONE
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTIMORE CITY.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 304 EAST 31st STREET. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM D. KIMPEL

3 (b) If veteran, name war: No

3 (c) Social Security Account No.: None

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: ~~Ann Kimpel~~

6 (c) If alive, give age * years

7. Birth date of deceased (mo., day, yr.) Oct.14-1856

8. AGE: Years 89 | Months 1 | Days 17 | If less than one day ... hr. ... min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Customs (Retired)

11. Industry or business

FATHER
12. Name George Kimpel
13. Birthplace Saxony

MOTHER
14. Maiden Name Agnes Lenzer
15. Birthplace Saxony

16 (a) Informant Emma K.Schmidt
(b) Address 304 E.31st.Street.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec.3-45 (month) (day) (year)
(c) Cemetery or crematory Moreland Memorial Pk,
Location Taylor Avenue

18 (a) Funeral director Chas. F. Evans & Son
(b) Address 118 W Mt Royal Ave.

19 (a) (Date rec'd by reg.) DEC 3 - 1945 (b) [signature] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH DEC 1 1945. 19 ; at 10.A M

21. I certify that death occurred on the date above stated; that I attended deceased from NOV 30 1945 to DEC 1 1945 and that I last saw him alive on DEC 1 1945.

Immediate cause of death	Duration
CHRONIC MYOCARDITIS NOV 30	1945.
Due to ARTERIOR SCLEROSIS	1945
Due to SENILITY.	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation NONE
Major findings of operation: NONE
of autopsy: NONE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M.D.
Address 3016 ST PAUL STREET DECEMBER 1 1945
Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634722

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

634722 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 705 E. 30th St.
(c) Hospital or institution: 9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 705 E. 30th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country No

3 (a) FULL NAME Ida Mae Mc Neal

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	White	Married

6 (b) Name of husband ~~or wife~~ J.W. Mc Neal
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 26 1890

8. AGE: Years	Months	Days	If less than one day
55	9	6	hr. min.

9. Birthplace Lexington Va (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business home

FATHER
12. Name James Mayse
13. Birthplace Lexington Va.

MOTHER
14. Maiden Name Catherine Crutcekfild
15. Birthplace Lexington Va

16 (a) Informant J.W. Mc Neal (Husband)
(b) Address 705 E. 30th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 5th/45 (month) (day) (year)
(c) Cemetery or crematory Moreland Memorial Park
Location 5806 Harford Rd.

18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Morley St.

19 (a) (Date received by registrar) (b) Registrar

DEC 3 - 1945

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 2 1945, at 11-15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 4 1945 to Dec 2 1945 and that I last saw h[illegible] alive on Dec 1 1945

Immediate cause of death Hypertensive Cardio Vascular Renal Disease — Duration ?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph Pokorny, M. D.
Address 2200 E Madison St Date signed 12/3/45

X

G34723

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G34723 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2619 Ailsa Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2619 Ailsa Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FREDA M. WRIGHTSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife Robert S. Wrightson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 30, 1865

8. AGE: Years 80 | Months 10 | Days 1 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John P. Schlesinger
13. Birthplace Germany

MOTHER
14. Maiden Name Schroepfer
15. Birthplace Germany

16 (a) Informant Mr. Otto P. Tillack, Jr.
(b) Address 2825 Rosalie Ave., Balto.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof Dec. 4, 1945 (month) (day) (year)
(c) Cemetery or crematory St. Pauls Lutheran
Location Violetsville, Md.

18 (a) Funeral director Lasselin Funeral Home
(b) Address 7401 Belair Road

19 (a) Dec 3 1945 (b) (Date received by registrar) Registrar

Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH December 1st, 1945, at 2 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 29 1945 to Dec 1 1945. and that I last saw h[illegible] alive on Dec 1 1945

Immediate cause of death: Cardio Resp Failure — Duration 2 hours

Due to Bronchopneumonia — 3 days

Due to

Other Conditions Arthritis & Spine — 3 months

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation

of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury None

23. Signature L. L. Leary M.D. M. D.

Address 5106 Harford Rd Date signed 12-3-45

VS 150

THOSE WHITE FIELDS, WITH UNFADING INK. Every item of information should be carefully supplied. The age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34724

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G34724
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Street City
(c) Hospital or institution:
Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 4

2. USUAL RESIDENCE OF DECEASED:
(a) State ..... (b) County .....
(c) City or town 1200 Valley St
(If outside city or town limits, write RURAL and give town)
(d) Street No. ..... (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Sophia Mauranski (Muranski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife .....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct 19, 1857

8. AGE: Years 84 | Months 2 1 | Days 12 | If less than one day ..... hr. ..... min. | 1861

9. Birthplace Russia Poland
(Town, county, and state)

10. Usual Occupation .....

11. Industry or business .....

FATHER
12. Name Stanislaus ?
13. Birthplace .....

MOTHER
14. Maiden Name Frances ?
15. Birthplace .....

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley St. City.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 4 1945 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 914 Greenmount Ave

19 DEC 3 1945 Date rec'd by registrar ..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 1 1945 at 1130 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1945 to Dec 1 1945 and that I last saw h[illegible] alive on Dec 1 1945

Immediate cause of death	Duration
Chronic Myocarditis	5 Yrs
Due to Arteriosclerosis	10 yrs
Due to	.....
Other Conditions	.....

(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? .....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature E. Gill Hall M. D.
Address 1631 E North Av Date signed Dec 2-45

VS 150

Huntington Williams, M.D.

G34725

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G34725 Registered No. 1700

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3819 Woodlea Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George L. Muller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Widowed

6 (b) Name of husband or wife Louise M. Hembolt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 19, 1876

8. AGE: Years	Months	Days	If less than one day
69	3	12	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business L. Greif & Bro. Inc.

FATHER
12. Name Frederick
13. Birthplace Germany

MOTHER
14. Maiden Name not known
15. Birthplace Germany

16 (a) Informant Gertrude Wockenfuss
(b) Address 3819 Woodlea Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/4/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North Ave & Rose St,

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 N. Broadway.

19 (a) (Date rec'd by reg.) (b) Wilmington, N.C.
DEC 3 - 1945 Huntington

MEDICAL CERTIFICATION

20. DATE OF DEATH December 1, 1945, at 2:20 A M

21. I certify that I took charge of the remains described above, held an Partial Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑ suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Depressed Fracture of skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury November 30 1945 27/11 10 P.M.
(b) Where did injury occur? York Rd & Homeland Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury Struck by auto

23. Signature Robert L. Fraker M.D. Medical Examiner.
Date signed 12-1-45

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34726

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 146B

G34726 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 729 E Preston St.
(c) Hospital or institution:
at Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 729 E. Preston St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** James J. McKay

3 (b) If veteran, name war: No

3 (c) Social Security Account No.:

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife (Nee Morgan): Mary F. McKay

6 (c) If give, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 25, 1878

8. AGE: Years 67 | Months 0 | Days 6 | If less than one day ... hr. ... min.

9. Birthplace Middlen Md. (Town, county, and state)

10. Usual Occupation Presser on Glass

11. Industry or business Swendale Mfg. Co.

FATHER 12. Name James McKay

13. Birthplace Ireland

MOTHER 14. Maiden Name Mary Ann Flannagan

15. Birthplace Ireland

16 (a) Informant Mrs. Mary F. McKay

(b) Address 729 E. Preston St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 4/45 (month) (day) (year)

(c) Cemetery or crematory Mayo Cathedral Cem

Location 4300 Old Frederick Rd

18 (a) Funeral director Elmer W. Conklin

(b) Address 924 E. Eager St.

19 (a) ... (b) ... (Date received by registrar) Huntington Williams M.D.

DEC 3 - 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 1st. 1945; at 11:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1945 to Dec 1, 1945, and that I last saw him alive on Nov 29 1945.

Immediate cause of death	Duration
Primary adeno-carcinoma of fundus of Stomach	1 yr
Due to Metastatic	
Due to Carcinoma of Liver	5 Mos
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation Gastroscopy 11/5/45

Major findings of operation: Carcinoma of Stomach

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William R Smith M.D.

Address 106 E. Beadle St Date signed 12/3/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34734 — BALTIMORE CITY HEALTH DEPARTMENT — CERTIFICATE OF DEATH 93D — Registered No. G34727

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 602 S. Washington Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 63 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 602 S. Washington Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MARTIN RYBIZKI

3 (b) If veteran, name war	3 (c) Social Security Account No.
----	----

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Anna
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 11, 1865

8. AGE: Years	Months	Days	If less than one day
80	-	19	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Station Watchman
11. Industry or business Railroad

FATHER
12. Name Casimir Rybizki
13. Birthplace Poland

MOTHER
14. Maiden Name Unknown
15. Birthplace Poland

16 (a) Informant Mr. Steven Rybizki
(b) Address 602 S. Washington Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/4/45 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location German Hill Road

18 (a) Funeral director M. J. Jagodzinski Sons
(b) Address 1808 Eastern avenue

19 (a) Date received by Registrar DEC 8 - 1945 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 30 1945, at 12:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 5 1945, to Nov. 30 1945, and that I last saw h— alive on Nov. 29 1945.

Immediate cause of death	Duration
Myocardial Insufficiency	2 days.
Due to: Chronic Myocarditis	2 yrs.
Due to:	
Other Conditions: Bronchial Asthma	2 yrs.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John V. Jagodzinski M. D.
Address 1802 Eastern Ave. Date signed 12-7-45

G3692819 — G347128

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937 — Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) .....
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3500 Hayward Ave.
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Frank Gillen

3 (b) If veteran, name war .....

3 (c) Social Security Account No. 220-05-9513

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife .....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 12-25-72

8. AGE: Years 72 | Months 11 | Days 7 | If less than one day ..... hr. ..... min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business .....

FATHER
12. Name Peter Gillen
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Walsh
15. Birthplace Ireland

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/5/46 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Old Frederick Rd

18 (a) Funeral director J. J. Daley & Sons
(b) Address 318 Light St.

19 (a) (b) Registrar
Date rec'd by DEC 3 1946 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 2 - 1946 at 4:22 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-28-1946 to 12-2-1946 and that I last saw him alive on 12-2-1946

Immediate cause of death — Duration
Cardiac failure — ?
Due to Heart block
Due to cardio-vascular disease & arteriosclerosis — ?
Other Conditions Benign Prostatic Hypertrophy

(Include pregnancy within 3 months of death)

Date of operation .....
Major findings of operation: .....
of autopsy .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? .....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature J. H. Armstrong M.D.
Address .....
Date signed 12/5/46

G34729

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1 a 1 69 / 937

Registered No. G34729

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 37 East York Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore City.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 37 East York Street
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michael Leo Hart

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alien, give age years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years 70 | Months — | Days — | If less than one day ____ hr. ____ min.

9. Birthplace Balto
(Town, county, and state)

10. Usual Occupation Porter

11. Industry or business —

FATHER 12. Name Thos. Hart

13. Birthplace Ireland

MOTHER 14. Maiden Name Cath. Hart

15. Birthplace Ireland

16 (a) Informant Chas. E. Hart

(b) Address 37 E. York St.

17 (a) Burial Dorsey (b) Date thereof 12/4/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet

Location Monument & Hoffman

18 (a) Funeral director Wm. F. Fahey Funeral Home

(b) Address 1316 E. Lafayette Ave.

19 (a) DEC 3 - 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 1 1945, at 10A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 5 1945 to Dec. 1, 1945 and that I last saw him alive on Dec. 1, 1945

Immediate cause of death: Acute cardiac Dilatation — Duration 1 day

Due to: Chronic myocardi tis — 5 mo?

Due to: Lobar pneu- monia — 1 day

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward Norris M. D.
Address 37 East West Street Date signed 12-1-45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 3

G34730

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1224

G34730 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood and Greene Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 3027 Abell Ave
(If outside city or town limits, write RURAL and give town)
(d) Street No. Balto. Md.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edwin M Kahoe

3 (b) If veteran, name war None Prior I
3 (c) Social Security Account No. 212-05-3922

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Married

6 (b) Name of husband or wife Theresa Griffith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/23/1885.

8. AGE: Years	Months	Days	If less than one day
55	11	29	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Draftsman
11. Industry or business Nat Cam Co.

FATHER
12. Name Edwin M. Kahoe
13. Birthplace Md.

MOTHER
14. Maiden Name Joanna Lyncea
15. Birthplace Md

16 (a) Informant Mrs E M. Kahoe
(b) Address 3027 Abell Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/4/45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Park Heights Ave
18 (a) Funeral director J. J. Foley Sons
(b) Address 218 Light St.
19 (a) DEC 3 1945 (b) Huntington Williamsport, Md
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/30 1945, at 9:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/26 1945 to 11/30 1945, and that I last saw him alive on 11/30 1945

Immediate cause of death Peripheral vascular collapse — Duration

Due to paralytic ileus

Due to

Other Conditions uremia

(Include pregnancy within 3 months of death)

Date of operation 11/26 and 11/29

Major findings of operation Gilat. inguinal hernia; Obstruction small intestine

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Don L. Otts Jr. M. D.
Address Univ. Hosp Balto Date signed 11/30/45

Otts Jr.

G34734

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

63B

G34731 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 521 W. Lanvale Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 521 W. Lanvale St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Henry Jenkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-25-1924

8. AGE: Years	Months	Days	If less than one day
21	3	7	hr. min.

9. Birthplace Calvert County, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Herman Jenkins
13. Birthplace Va.

MOTHER
14. Maiden Name Margaret McCoy
15. Birthplace Md.

16 (a) Informant Margaret McCoy
(b) Address 521 W. Lanvale St.

17 (a) Burial (b) Date thereof 12-5-45
(Burial, cremation, or removal) (month), (day), (year)
(c) Cemetery or crematory YOUNGS-CHAPEL-CEM
Location CALVERT County Md.

18 (a) Funeral director William A Jackson
(b) Address 916 Pemb ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 2, 1945, at 11 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cardiac hypertrophy & dilatation

Due to Hypertheyroidism

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Grattan M.D.
Medical Examiner.
Date signed Dec. 3 1945

Notice: Age is supremely important. Physicians: please write the causes of death clearly and legibly.

G347:42

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46M

G347:42 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution: Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 d
(e) Length of stay in Baltimore (yrs., mos., or days) 35 y.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1614 W. Fayette St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Frank Bandjunis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	M.

6. (b) Name of husband or wife Julia Ann Zalunas
6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) Dec. 3, 1887

8. AGE: Years	Months	Days	If less than one day
57 58	11	29	hr. min.

9. Birthplace Lithuania (Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business Burke & Freedman.

FATHER
12. Name Georg Bandjunis
13. Birthplace Lithuania

MOTHER
14. Maiden Name Anna Blandjavitis
15. Birthplace Lithuania

16 (a) Informant Antonia Danielson
(b) Address 1614 W. Fayette

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 5-45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd

18 (a) Funeral director Joseph Kensinger Jr.
(b) Address 6 St Paul Pl

DEC 3 - 1945 (Date rec'd by registrar) (b)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/2 1945 at 9:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/19 1945 to 12/2 1945 and that I last saw h. i. alive on 12/1 1945.

Immediate cause of death Cardio-Respiratory Failure

Duration

Due to Gastric Intestinal Hemorrhage
Due to Malignancy of Cardia of Stomach
Other Conditions Belatural
Arteriosclerosis
(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation:
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. T. Brendle M. D.
Address Mercy Hosp. Date signed 12/2/45

Huntington Hobbs

X

VS 150

G34733

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

G34733

Registered No.

AB- 97554

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

5-L

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2days

(e) Length of stay in Baltimore (yrs., mos., or days) 16 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1123 E. Lexington St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Betty Barnes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Separated

6 (b) Name of husband or wife Andrew

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?-?-? 39?

8. AGE: Years	Months	Days	If less than one day
39?	?	?	hr. min.

9. Birthplace New Jersey
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name ?

13. Birthplace ?

MOTHER

14. Maiden Name ?

15. Birthplace ?

16 (a) Informant Baltimore City Hospitals (Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 12-5-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Calvery

Location

18 (a) Funeral director Elroy O. Wilson

(b) Address 1000 Bland Lane

19 (a) (b)
(Date rec'd by registrar)

Huntington Williams, Registrar

DEC 3 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 30- 1945, at 7.30 AM M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-28- 1945, to 11-30- 1945, and that I last saw her alive on 11-30- 1945.

Immediate cause of death	Duration
Cardiac failure	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: none

of autopsy: Enlarged heart, Syph. Aortitis

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature T. P. Jernigan

Address Baltimore City Hosp. Date signed 12-3-45
M. D.

Jernigan X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34734 G34734

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 118

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 44 Market Place
(c) Hospital or institution: Emergency Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 44 Market place
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Hannah Mallory

3 (b) If veteran, name war: 1st World War
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 11 1889

8. AGE: Years 56 | Months 3 | Days 21 | If less than one day ... hr. ... min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Practice

11. Industry or business

FATHER
12. Name Wm. Mallory
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah Brown
15. Birthplace Md.

16 (a) Informant Mrs Marguerite Hendricks
(b) Address 46 Lesley Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 5/45 (month) (day) (year)

(c) Cemetery or crematory Balto National
Location Balto County

18 (a) Funeral director A. Howard Evans
(b) Address 400 S. Harbor Pl

DEC 3 1945

19 (a) ... (Date rec'd by reg.) (b) Washington Williams, M.D. Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 2 1945, at 3:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/2 1945 to 12/3 1945 and that I last saw h[im] alive on 12/2 1945.

Immediate cause of death Anasarca

Due to Cardiac - Renal Failure

Due to Hemorrhage (Gastric)

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
over

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. M. Scott M. D.
Address Community Hosp Date signed 12/5/45

G34735 — BALTIMORE CITY HEALTH DEPARTMENT — G34735

CERTIFICATE OF DEATH 931

Registered No.

Please write plainly, with UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3301 EDMONDSON AVE.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) 50 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 3301 EDMONDSON AVE. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANTONIA DAMICO

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. NONE

4. Sex: FEMALE | 5. Color or race: WHITE | 6 (a) Single, married, widowed, or divorced: WIDOWED

6 (b) Name of husband or wife SALVATORE

6 (c) If alive, give age ✓ years

7. Birth date of deceased (mo., day, yr.) MAR. 16-1881

8. AGE: Years 64 | Months 8 | Days 16 | If less than one day hr. min.

9. Birthplace ITALY (Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business HOME

FATHER
12. Name JOSEPH GUGLIUZZA
13. Birthplace ITALY

MOTHER
14. Maiden Name PHILIPINA CARDIRONA
15. Birthplace ITALY

16 (a) Informant MR. VINCENT DAMICO
(b) Address 3301 EDMONDSON AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12-5-45 (month) (day) (year)
(c) Cemetery or crematory CATHEDRAL
Location EDMONDSON AVE.

18 (a) Funeral director C. RAYMOND RAUENHORST
(b) Address 1076 LEEDS AVE.

19 (a) (b) Registrar
(Signature of registrar) DEC 3 1945
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 2 1945, at 1:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1945 to Dec 2 1945 and that I last saw h[illegible] alive on Dec 2 1945.

Immediate cause of death — Duration

(a) Arteriosclerotic
Due to heart disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. J. Kirby, M.D.
Address 1106 N. Howard St. Date signed 12/3/45

634736

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

634736

Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greene & Lombard
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 7 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Tal Talbot
(c) City or town Cordova, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Cordova
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Alfred Knaack

3 (b) If veteran, name war —
3 (c) Social Security Account No. — —

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — 1925

8. AGE: Years 20 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation engineer
11. Industry or business

FATHER 12. Name Alfred Knaack
13. Birthplace Wisconsin

MOTHER 14. Maiden Name Verna Swinteman
15. Birthplace Nebraska.

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 6 45 (month) (day) (year)
(c) Cemetery or crematory Spring Hill
Location Easton, Md.

18 (a) Funeral director Stewart & Mowen Co
(b) Address 108-W- North Av.

19 (a) Dec 9 1945 Huntington Williamsport Md.
(Registrar's signature)

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 3 1945 at 9 55 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from ... 19..., to Dec. 3 1945 and that I last saw h.. alive on Dec 3 1945

Immediate cause of death Brain abscess — Duration ...
Due to Bronchiectasis — ...
Due to Lung abscess — ...
Other Conditions ...
(Include pregnancy within 3 months of death)
Date of operation 11-30-45
Major findings of operation: Removal Lower left lobe of lung.
of autopsy: ...

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ...
(b) Date of occurrence ... at ... M
(c) Where did injury occur? ... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ... While at work? ... (Specify type of place)
(e) Means of injury ...

23. Signature M. Dorcas Clark M. D.
Address University Hospital Date signed 12-3-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34737

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

G34737 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 340 Camel St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 340 Camel St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie T. Green

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-03-9646

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May-5-1903

8. AGE: Years 40 | Months 6 | Days 27 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Laundry Work.

11. Industry or business

FATHER 12. Name Charles C. Thornton

13. Birthplace Md.

MOTHER 14. Maiden Name Mary E. Johnson

15. Birthplace Md.

16 (a) Informant Louise Thornton

(b) Address 911 Jordan St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-5-1945 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary Cemetery

Location Catonsville Md.

18 (a) Funeral director Adolphus Halstead

(b) Address 918 Druid Hill Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

DEC 3 - 1945 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-2 1945, at 6.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from [illegible] and that I last saw h[illegible] alive on [illegible] 1945

Immediate cause of death [illegible] Duration

Heart [illegible]

Due to [illegible]

Due to Hard work

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.

Address [illegible] Date signed 12/6/45

G34738 — BALTIMORE CITY HEALTH DEPARTMENT — G34738 Registered No.

CERTIFICATE OF DEATH

83a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3806 Milford Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 28-1
(e) Length of stay in Baltimore (yrs., mos., or days) 3845.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3806 Milford Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin C Flonton

3 (b) If veteran, name war None
3 (c) Social Security Account No. None

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 7 1884

8. AGE: Years 61 | Months 3 | Days 29 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Retired - Clerk

11. Industry or business Grocery

FATHER
12. Name Benjamin Flonton
13. Birthplace Virginia

MOTHER
14. Maiden Name Catherine Cook
15. Birthplace Virginia

16 (a) Informant Richard Jr. Flonton
(b) Address 3806 Milford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 4 1945 (month) (day) (year)
(c) Cemetery or crematory Western Cemetery
Location Baltimore, Md.

18 (a) Funeral director E Wallis Sumwalt
(b) Address 4510 Liberty Heights Ave

19 (a) (Date rec'd by registrar) (b) Registrar

DEC 3 - 1945
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 1 1945, at 9 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1945 to Dec 1 1945 and that I last saw h alive on Dec 1 1945.

Immediate cause of death: Cerebral Vascular accident — Duration: 1 day
Due to: Arteriosclerosis — 6 mos.
Due to: Mental Problem — 10 yrs.
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thos F Abbott
Address 4509 Liberty Heights Ave Date signed 12/3/45 M. D.

Huntington Williams, M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Ward 4 Epsom Case

BALTIMORE CITY HEALTH DEPARTMENT ✓ 634739

CERTIFICATE OF DEATH 108

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 -
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 213 Belnord Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harold Rapp

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: White | 6 (a) Single, ~~married, widowed, or divorced~~: Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 4th 1945

8. AGE: Years | Months: 4 | Days: 28 | If less than one day: hr. min.

9. Birthplace: Balto. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Harold Rapp Jr.
13. Birthplace Norristown Pa.

MOTHER
14. Maiden Name Anna Barnabei
15. Birthplace Balto. Md.

16 (a) Informant Harold Rapp Jr and Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/4/45 (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Parkville Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul st

19 (a) (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec - 2 - 1945 at 11 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/2 1945 to 12-2 1945 and that I last saw h/m alive on 12/2 1945

Immediate cause of death Died within two minutes after birth. No physical pain done

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy? Pneumonia Atelectasis

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. H. Mariconda, Jr. M. D.

Address 12/3/45 Date signed

VS 150 Approved, Robert Lee Dorsey M.D. Johns Hopkins Hosp.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6347-0

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 6347-0

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3106 Louise Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3106 Louise Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Calista E. Macleod

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) ~~Single, married~~, widowed, or ~~divorced~~ Widowed

6 (b) Name of husband ~~of wife~~ Kenneth E. Macleod

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 24th 1863

8. AGE: Years 82 | Months 1 | Days 7 | If less than one day hr. min.

9. Birthplace Nova Scotia
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business Self

FATHER
12. Name Judson Beals
13. Birthplace Nova Scotia

MOTHER
14. Maiden Name Tracy Mc Gregor
15. Birthplace Nova Scotia

16 (a) Informant Mrs. Bertha M. Ferguson
(b) Address 3106 Louise Ave

17 (a) Burial (b) Date thereof 12/4/45
(Burial, ~~cremation, entombment~~) (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Parkville Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul Wilkens Ave

19 (a) 1945 (b) Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 1st 1945, at 6 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 10 1945, to Dec 1 1945, and that I last saw h~~e~~r alive on Dec 1 1945.

Immediate cause of death	Duration
Hypostatic Pneumonia	2 days
Due to Myocardial degeneration	6 mos.
Due to arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward Novak
Address 101 W. Read St Date signed Dec 3. 45 M. D.

VS 150

Examined: Robert C. Fentress M.D.

PRINT WITH PENCIL, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634741

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

6312nd

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2121 Homewood Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2121 Homewood Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin D. Clapp

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	214-14-2841

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Wanda H. Clapp
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 10, 1889

8. AGE: Years	Months	Days	If less than one day
56	3	23	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation salesman
11. Industry or business Free State Brewery

FATHER
12. Name William Clapp
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary Sherwood
15. Birthplace Baltimore

16 (a) Informant Wanda H. Clapp
(b) Address 2121 Homewood Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/6/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Maryland

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) 12/4/45 (Date rec'd by reg.) (b) Washington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 3 1945 at 11a M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 29 19 45 to Dec 3 19 45 and that I last saw h alive on Dec 3 19 45

Immediate cause of death	Duration
Edema of lungs	2 days
Due to	
Due to	
Other Conditions Cancer of Rectum (Include pregnancy within 3 months of death)	5 yrs.

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature M. L. Lichtenberg
Address 7085 North Ave Date signed 12/3/45 M. D.

VS 150

G34742

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 939

Registered No. G34742

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2301 E. Hoffman st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2301 E. Hoffman St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George T. Robinson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of ~~husband~~ or wife: Agnes V. Robinson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 16th 1865

8. AGE: Years 80 | Months 10 | Days 16 | If less than one day hr. min.

9. Birthplace Kansas (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Colonel

FATHER
12. Name George T. Robinson
13. Birthplace ?

MOTHER
14. Maiden Name Mary E. Olwine
15. Birthplace Balto. Md.

16 (a) Informant Elsie M. Loftus
(b) Address R.F.D. #3 Box 770 Annapolis Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 5th 1945 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Green Mount
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul

19 (a) (Date rec'd by registrar) (b) Huntington Williamsport, Md. Registrar

DEC 4

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 2nd 1945, at 8 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 20 1945, to Dec 1 1945 and that I last saw him alive on Dec 1 1945.

Immediate cause of death	Duration
Coronary Occlusion	Twhrs
Due to Chronic Myocarditis	
Due to + General Arteriosclerosis	10 yrs
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Francis J. Cook

Address 2005 E. Fremont St Date signed M. 12 D. 3/45

VS 150

X

A number will be assigned by the registrar. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34743

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 92D ✓

G34743 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 642 Portland st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 642 Portland st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Salvatore Vinci

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Concetta Vinci
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 8 1861

8. AGE: Years	Months	Days	If less than one day
84	2	29	hr. min.

9. Birthplace Sicily (Town, county, or state)
10. Usual Occupation Retired Laborer
11. Industry or business B & O R.R.

FATHER
12. Name Salvatore Vinci
13. Birthplace Sicily

MOTHER
14. Maiden Name Anna Brocato
15. Birthplace Sicily

16 (a) Informant Salvatore Vinci
(b) Address 642 Portland St.

17 (a) Burial (b) Date thereof 12/5/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul West Williams, Md

19 (a) (Date rec'd by Registrar) (b) Registrar

DEC 1 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 2nd 1945, at 8 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1945 to Dec 2 1945 and that I last saw h[illegible] alive on Dec 1 1945

Immediate cause of death	Duration
Acute cardiac thrombosis coronary	48 hrs.
Due to Valvular disease of heart	2 years
Due to arthritis -	? yrs.
Other Conditions old age	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature S. J Cantrell M. D.
Address Medical Arts Bldg Date signed 12/3/45

X

G34744

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95a

Registered No. G34744

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address CATON + WILKENS AVES.
(c) Hospital or institution:
ST. AGNES HOSP.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 1/2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTIMORE
(c) City or town ~~EDMONDSON~~ CATONSVILLE
(If outside city or town limits, write RURAL and give town)
(d) Street No. EDMONDSON AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MRS CATHERINE BALDOFF

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	MARRIED

6 (b) Name of husband or wife ARTHUR
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 27th 1861

8. AGE: Years	Months	Days	If less than one day
84	0	6	hr. min.

9. Birthplace Balto. MARYLAND
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name JOHN OEHS
13. Birthplace GERMANY

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Arthur Baldorf
(b) Address Edmondson Ave. Hunterly Lane

17 (a) Burial (b) Date thereof 12/6/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 127 St. Paul st

19 (a) (Date rec'd by registrar) (b) Registrar

vs DEC 4 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/3/1945, at 3:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/1 1945 to 12/3 1945 and that I last saw h2R alive on 12/3 1945

Immediate cause of death Cardiac failure.

Due to Complete Heart Block

Due to Auricular fibrillation & Embolii

Other Conditions Bilateral Hypostatic Pneumonia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Clara E. Carlson M.D.
Address Hayes Hosp. Date signed 12/3/45

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634745

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G34745

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1101 Webb Court
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1101 Webb Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William H. Siemer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
Male	White	Married

6 (b) Name of ~~husband or wife~~ Nana Siemer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 11th 1870

8. AGE: Years	Months	Days	If less than one day
75	7	21	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Clerk

FATHER
12. Name Wm H. Siemer
13. Birthplace Germany

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Phillip W. Siemer
(b) Address 1701 Wicke Ave.

17 (a) Burial (b) Date thereof 12/5/45
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery or ~~crematory~~ London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

19 (a) DEC 4 - 1945
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 2nd 1945, at 10 45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1, 1945 to Dec 2, 1945, and that I last saw h[im] alive on Dec 1 1945.

Immediate cause of death	Duration
Cerebral hemorrhage	
Due to Arterio-sclerosis	24 hours
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm Greenfield M. D.
Address 1821 Eutaw Pl Date signed 12/3/45

Huntington Williams, M.D.

634746

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 44B

634746 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2560 Boyd St.
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2560 Boyd St
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) **FULL NAME** Howard L. Buckingham

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Miriam Mensel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 18-1900

8. AGE: Years 45 | Months 0 | Days 14 | If less than one day ... hr. ... min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

FATHER 12. Name Roy P. Buckingham

13. Birthplace Md

MOTHER 14. Maiden Name Mary A. Partington

15. Birthplace Md

16 (a) Informant Mrs. Miriam M. Buckingham

(b) Address 2558 Boyd St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-5-45 (month) (day) (year)

(c) Cemetery or crematory Western

Location Balto - Md

18 (a) Funeral director Geo. L. Beyer Jr

(b) Address 1612 Hollins St

19 (a) DEC 4 1945 (Date received by Registrar) (b) ... Registrar

VS 180

Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH December 2 1945, at 2.30 a.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 11 1945, to Dec 2 1945, and that I last saw him alive on Dec 1, 1945.

Immediate cause of death: Disseminated Hodgkins disease — Duration 6 months

Due to: —

Due to: —

Other Conditions: —

(Include pregnancy within 3 months of death)

Date of operation: —

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence ... at ... M

(c) Where did injury occur? ... (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? ... (Specify type of place) While at work? ...

(e) Means of injury: —

23. Signature Leonard Yaffe M.D.

Address 310 (W) Baltimore St Date signed 12/5/45

M. D.

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34747 ✓ G34747

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 22 S. Athol Ave.
(c) Hospital or institution: Henry Furman Aged People Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 22 S. Athol Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Spink

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	married

6 (b) Name of husband or wife Augusta Naw Spink
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15, 1865

8. AGE: Years	Months	Days	If less than one day
80	6	15 17	hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name George Spink
13. Birthplace Prussia.

MOTHER
14. Maiden Name Anna Blake
15. Birthplace Md.

16 (a) Informant Mr. George Waltz
(b) Address 22 S Athol Ave.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 12/4/45 (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3801 Frederick Rd

18 (a) Funeral director Harry N. Witzke
(b) Address 4101 Edmondson Ave.

19 (a) DEC 2 1945 (Date rec'd by Registrar) (b) Registrar
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION P.

20. DATE OF DEATH Dec. 1 1945, at 3.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1/45 to Dec. 1/45, and that I last saw him alive on Nov. 27/45.

Immediate cause of death: Arterio-Sclerosis. — Duration: Unknown.

Due to

Due to Unknown.

Other Conditions Cardiac Hypertrophy.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry Nuell Queen M. D.
Address 920 Hamilton Date signed Dec 3 1945
97.

634748 (David) DAVIS WISE. 634748

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

Please write the causes of death clearly and legibly. Correct age is especially important. Physicians: please write your name plainly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) 23 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 607 N. Paca St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (David) Davis Wise

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	Col	Married

6 (b) Name of husband or wife Clinnie Wise

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 12-8-1902.

8. AGE: Years	Months	Days	If less than one day
42	11	25	hr. min.

9. Birthplace S.C.
(Town, county, and state)

10. Usual Occupation Porter

11. Industry or business Westminster Hotel

FATHER
12. Name Henry Wise
13. Birthplace S.C.

MOTHER
14. Maiden Name Eliza Lope
15. Birthplace S.C.

16 (a) Informant Clinnie Wise
(b) Address 607 N. Paca

17 (a) Shipped (b) Date thereof 12-6-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Johns Lem
Location Laurel S.C.

18 (a) Funeral director William A. Jackson
(b) Address 916 Pennsylvania Ave

19 (a) (b)
(Date rec'd by registrar) (Registrar)

DEC 4 1945 Washington Williams, Jr.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/3 1945, at 4:44 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature E. D. Lubinski M.D.
Medical Examiner.
Date signed 12/3/45

G34749

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157a

G34749 Registered No.

IN. 97515

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals 13 7
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 10 Weeks

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3982 Elm Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Tena Elizabeth Parker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 15th 1945

8. AGE: Years | Months: 2 | Days: 17 | If less than one day: hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Oscar Parker
13. Birthplace Maryland

MOTHER
14. Maiden Name Frances Petty
15. Birthplace S. C

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 4/45 (month), (day) (year)
(c) Cemetery or crematory St. Marys
Location Hampden

18 (a) Funeral director Ehrenwerth & Donovan
(b) Address 3615-17 Chestnut Ave

19 (a) (Date rec'd by registrar) (b) Burial Permit Issued, M.D.

DEC 4 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 2nd 1945 19 at 3.40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 26th 19 45 to Dec 2nd 19 45 and that I last saw her alive on Dec 2nd 19 45

Immediate cause of death: Hydrocephalus — Duration: Life

Due to: Congenital defect

Due to:

Other Conditions: Nursing on placed

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter M Tasent M. D.
Address 804 Date signed 12/3/45

PRESS WHITE FIRMLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Schreiber
54 E. Fulton Ave.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30C

Registered No. 634750

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3555 Sweet Air St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3555 Sweet Air St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lydia F. Lewis.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: widow.

6 (b) Name of husband or wife: Joseph P. Lewis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 18, 1888

8. AGE: Years 57 | Months 5 | Days 14 | If less than one day hr. min.

9. Birthplace Maryland. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John H. Ellis
13. Birthplace Virginia.

MOTHER
14. Maiden Name Cora A. Lewis
15. Birthplace Virginia.

16 (a) Informant Mrs. Pauline V. Packer
(b) Address 3683 Ash St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 5/45 (month) (day) (year)
(c) Cemetery or crematory St. Mary's
Location Hamsdale
18 (a) Funeral director Chamberlain Donovan
(b) Address 3615-17 Chestnut Ave.
19 (a) DEC 4 - 1945 (Date rec'd by registrar) Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 2, 1945, at 9 40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1943 to Dec. 2 1945, and that I last saw her alive on Dec. 1 1945.

	Duration
Immediate cause of death: Cerebral Hemorrhage	3 days
Due to Pulmonic Anemia	3 days
Due to C. N. S. Syphilis	?
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. B. Schreiber M. D.
Address 548 Fulton Ave Date signed 12-4-45

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34751

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95B

G34751 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2205 Elsinor Ave.
(c) Hospital or institution:

15-4

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ***
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2205 Elsinor Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Laura P. Chambers

3 (b) If veteran, name war: --

3 (c) Social Security Account No. None

4. Sex: Female

5. Color or race: Wht.

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: M. Harrison Chambers

6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) Jan. 1, 1876

8. AGE: Years 69 | Months 11 | Days 2 | If less than one day ... hr. ... min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation House-wife

11. Industry or business

FATHER
12. Name John B. Pursley
13. Birthplace Virginia

MOTHER
14. Maiden Name Maria Roberts
15. Birthplace Virginia

16 (a) Informant M. Harrison Chambers
(b) Address 2205 Elsinor Ave. (16)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 5/45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md.

18 (a) Funeral director Robert S. Little
(b) Address 2700 Edmondson Ave.

19 (a) DEC 4 1945 (b) ... Registrar
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 5 1945, 1:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-1-1942 to 12-5-1945; and that I last saw h[illegible] alive on 12-2-1945.

Immediate cause of death	Duration
Coronary Occlusion	1 day
Due to Rheumatic heart disease	8 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Howard F. Warren M. D.
Address 260 W. Garrison Blvd Date signed 12-3-45.

X

A4464452

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157a

Registered No. 634752

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Fla. (b) County
(c) City or town Miami
(If outside city or town limits, write RURAL and give town)
(d) Street No. 244 Northwest 74th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Diane Miller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/1945

8. AGE: Years | Months: 2 | Days | If less than one day: hr. min.

9. Birthplace Fla.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Franklin Miller
13. Birthplace Iowa

MOTHER
14. Maiden Name Lucille Lutter
15. Birthplace Iowa

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 4/1945 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Frederick Ave

18 (a) Funeral director C. Mitchell & Son.
(b) Address 1901 Eutaw Place,

19 (a) (Date rec'd by registrar) (b) Registrar

DEC 4 - 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 1 1945 at 8:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-27- 1945 to 12-1- 1945 and that I last saw her alive on 12-1- 1945.

Immediate cause of death: cessation respiration — Duration

Due to: Hydrocephalus — post operatively

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation 11-29-45

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. M. Morrison Jr.

Address Johns Hopkins Hosp. Date signed 12/4/45

X

G34753

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G34753 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd + Calvert St.
(c) Hospital or institution:
Union Memorial Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14½ hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 75 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County -------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Tudor Arms Apartments
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME [redacted] (Jeannette) Sherwood

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Mr. John H. Sherwood
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) July 19, 1870 (1870)

8. AGE: Years	Months	Days	If less than one day
75	4	18	..... hr. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Hamilton S. Hoggson
13. Birthplace Scotland

MOTHER
14. Maiden Name Mary Anne Cunningham
15. Birthplace Connecticut

16 (a) Informant Miss Robina Sherwood
(b) Address Tudor Arms Apartments, Cty

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/6/45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn, Md.

18 (a) Funeral director H. W. Mears and Son
(b) Address 805 N. Calvert Street

19 (a) [illegible] (b)

DEC 4 - 1945 Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 2, 1945, at 9:10 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1, 1945 to Dec 2, 1945, and that I last saw her alive on Dec 2 1945.

Immediate cause of death Coronary Thrombosis

Due to .....

Due to .....

Other Conditions Arteriosclerotic C-V disease.
(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? .....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature J. Frank Hoggson III
Address Union Memorial Hospital Date signed 12/3/45

634754

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D ✓

634754 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mt Baltimore General 14

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) DOA

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 620 John (If rural give location)
(e) Citizen of foreign country? ------- (Yes or No)
If yes, name country -------

3 (a) FULL NAME Harry Casey (Harry A. Casey)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife ---------

6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) -------- 1881

8. AGE: Years 64 | Months --- | Days --- | If less than one day -- hr. --- min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation None (Retired)

11. Industry or business ------

FATHER
12. Name Andrew H. Casey
13. Birthplace England

MOTHER
14. Maiden Name Mary Quayle
15. Birthplace Maryland

16 (a) Informant Mrs. George Jenkins
(b) Address 414 Southway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/5/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Mears and Son
(b) Address 805 N. Calvert Street

19 (a) (Date rec'd by registrar) DEC 4 - 1945 (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/2/45 19..., at 3:15 P M

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy / Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John L. Weeks M.D. Medical Examiner.
Date signed 12/2/45

VS 151

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634755

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. 634755

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3605 Cottage Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 12
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3605 Cottage Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Steinberg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: La te Morris

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years 70 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business House Work

FATHER
12. Name Kopel Berlin
13. Birthplace mRussia

MOTHER
14. Maiden Name Ida ?
15. Birthplace Russia

16 (a) Informant Ellis Steinberg
(b) Address 560 5 Cottage Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof December 4, 1945 (month) (day) (year)
(c) Cemetery or crematory Hebrew Herring Run Cem
Location Bowleys Lane

18 (a) Funeral director Sol Levinson & Brod
(b) Address 1124-1126 W North Ave

DEC 4 - 1945 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION 10.30

20. DATE OF DEATH December 5 19 45 at P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1944 19 to 12/3/45 19, and that I last saw h alive on 12/3/45 19.

Immediate cause of death Coronary occlusion — Duration 7

Due to

Due to

Other Conditions Diabetes mellitus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature]
Address 7904 Rust Rd Date signed M. 12/4/45 D.

VS 150

94a

634756

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170C

Registered No. 634756

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: South Baltimore Gen'l Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D. O. A.
(e) Length of stay in Baltimore (yrs., mos., or days) D. O. A.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. Severna Park (Or location) Old Annapolis Road
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Calvin T. Barrett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 17, 1924

8. AGE: Years: 21 | Months: 0 | Days: 14 | If less than one day: hr. min.

9. Birthplace Bel Air, Harford Co, Md.
(Town, county, and state)

10. Usual Occupation General Work

11. Industry or business P. F. C. Chemical Co, Fairfield

FATHER
12. Name Samuel M. Barrett
13. Birthplace Penna.

MOTHER
14. Maiden Name Mollie Tracey
15. Birthplace Phoenix, Balto. Co, Md.

16 (a) Informant Mrs. Mollie M. Barrett.
(b) Address Severna Park, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 45 (month) (day) (year)
(c) Cemetery or crematory Tessum Cem.
Location Cockeysville, Md.

18 (a) Funeral director Roman W. Ensminger
(b) Address Glen Burnie, Md.

DEC 4 - 1945 (Date rec'd by Registrar) (b) Huntington Williamsport, Md.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 1, 1945, at 7:45 P. M.

21. I certify that I took charge of the remains described above, held an Partial Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Skull Fracture with maceration of brain

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-1-45 at 7:15 P. M.
(b) Where did injury occur? Old Annapolis Rd. A.A.Co.
(c) Did injury occur at home, on farm, industrial place, in public place? Public. While at work? No.
(d) Means of injury Passenger in auto which struck fixed object.

23. Signature Benedict Skitarelis M.D.
Medical Examiner.
Date signed December 2, 1945

634757

BALTIMORE CITY HEALTH DEPARTMENT ✓ 634757

CERTIFICATE OF DEATH 58E

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 7 12
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2429 E. Madison St (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Theresa Hergenrother

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 6, 1890

8. AGE: Years 55 | Months [redacted] | Days [redacted] | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name John Hergenrother
13. Birthplace Maryland

MOTHER 14. Maiden Name Barbara Yekel
15. Birthplace Germany

16 (a) Informant Frederick Hergenrother
(b) Address 2429 E. Madison St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/6/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director C. Schimunek
(b) Address 2401-03 E. Madison St

19 DEC 4 - 1945 (Date received by registrar) Huntington Williams M.D. (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 3 1945, at 1:35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 30 1945, to Dec 3 1945, and that I last saw h[illegible] alive on Dec 3 1945.

Immediate cause of death: Cardiac Failure — Duration ?

Due to: probable rheumatic fever

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thos. E. Wheeler M. D.
Address South Balto. Gen. Hosp. Date signed 12-5-45

VS 150

med Exam case
G34[illegible] 369882

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. 634758

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 6-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County BALTO.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1927 E. Fayette St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Schwarzel

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NONE

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Wilhelm
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-10-05

8. AGE: Years 40 | Months 5 | Days 22 | If less than one day: hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business AT HOME

FATHER
12. Name Thos. Odea
13. Birthplace Md.

MOTHER
14. Maiden Name Catherine Rainey
15. Birthplace Md.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof DEC. 6/45 (month) (day) (year)
(c) Cemetery or crematory NEW CATHEDRAL
Location OLD FREDERICK ROAD

18 (a) Funeral director Lilly & Zeiler Inc.
(b) Address 403 S. WOLFE ST.

19 (a) (Date received by registrar) DEC 4 1945 (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 2, 1945 at 10.35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1 1945 to Dec. 2 1945 and that I last saw her alive on Dec. 2 1945

Immediate cause of death: Subarachnoid Hemorrhage — Duration 6 days
Central Nervous System Damage:
Due to Blow on Head & Fall
Hemorrhage in Subarachnoid Region
Due to Trauma from Fall
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation 12/2/45
Major findings of operation: Massive Hemorrhage in Subarachnoid Region
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 6/4
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 11/27/45 at 5 P.M.
(c) Where did injury occur? Baltimore (City or town) Md. (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? home (Specify type of place) While at work? No
(e) Means of injury Fall on Steps

23. Signature J. E. Cowan III M.D.
Address Johns Hopkins Hosp. Date signed 12/2/45

For Dr. J. R. Davis, by Howard D. Mallory, M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634759

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 50

634759
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 501 Gold St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 501 Gold St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Henrietta Matthews

3 (b) If veteran, name war

3 (c) Social Security Account No. None.

4. Sex Female

5. Color or race Colored

6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Harry R.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 6, 1885

8. AGE: Years 59 | Months 11 | Days 25 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER 12. Name Charles Johnston

13. Birthplace Maryland

MOTHER 14. Maiden Name Lucy Cook

15. Birthplace Maryland

16 (a) Informant Charles H. Johnston

(b) Address 2456 Mc Culloh St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 4 1945 (month) (day) (year)

(c) Cemetery or crematory St. Thomas

Location Randallstown, Md.

18 (a) Funeral director Wm. Jas. H. Holland

(b) Address 1631 Druid Hill Ave.

19 (a) DEC 4 - 1945 (b) Filed by registrar Easton Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-1 1945, at 1 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1945 to 12-1 1945 and that I last saw alive on 12-1 1945

Immediate cause of death — Duration

Carcinomatosis

Due to Primary - Unknown

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. S. Butler M. D.

Address 2031 Druid Hill Ave Date signed 12/4/45

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34760 — BALTIMORE CITY HEALTH DEPARTMENT — G34760

CERTIFICATE OF DEATH 48a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5008 Orville Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs 10 mo

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5008 Orville Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma West Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No. 116-16-3765

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Burton Van Loon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/20/1894

8. AGE: Years	Months	Days	If less than one day
51	7	13	hr. min.

9. Birthplace: Schenevus N.Y.
(Town, county, and state)

10. Usual Occupation: Nurse

11. Industry or business

FATHER
12. Name: William West
13. Birthplace: South Worcester N.Y.

MOTHER
14. Maiden Name: Eudora Cole
15. Birthplace: Livingstonville N.Y.

16 (a) Informant: Mr. burton Johnson
(b) Address: 5008 Orville Ave.

17 (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof 12/4/45 (month) (day) (year)
(c) Cemetery or crematory
Location: SCHENEVUS, NEW YORK

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: NORTH & PA. AVES

19 (a) (Date rec'd by registrar) (b) [illegible] Registrar

DEC 4 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 3 1945, at 9:02 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 20 1943 to Dec 3 1945, and that I last saw her alive on Dec 3 1945.

Immediate cause of death: Carcinoma of Cervix — Duration: 3 yrs

Due to: metastasis to Bladder & Rectum — 8 mo

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Coral Gordon M. D.
Address 2201 W. North Ave Date signed 12-3-45

G34701 BALTIMORE CITY HEALTH DEPARTMENT ✓ G34701
Registered No.

CERTIFICATE OF DEATH 109a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3404 Callaway Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3404 Callaway Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jerusha G. McFarland

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife J. Norris McFarland
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 13, 1884

8. AGE: Years	Months	Days	If less than one day
61	8	18	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business None

FATHER
12. Name George Mills
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Nellie R. Rowland
15. Birthplace Richmond Va.

16 (a) Informant Mr. J Norris McFarland
(b) Address 3404 Callaway Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 5 1945 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director Wm. J. Tickner And Sons
(b) Address North And Penna Aves.

19 (a) (Date rec'd by registrar) (b) Registrar

DEC 4 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 1 1945, at 4 P. M abmf

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1, 1940 19 to Dec 1 1945
and that I last saw her alive on Dec 1 1945

Immediate cause of death Virus Pneumonia — Duration 3 wks

Due to

Due to

Other Conditions Infectious arthritis → 9 yrs
Sardiac failure (2 wks)
(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation —
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury

23. Signature Jas A Tuckner M. D.
Address 12 E Eager St Date signed Dec 3/45

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634762

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 45a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Ave
(c) Hospital or institution:
St. Agnes Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2327 W. Lanvale (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Theodora V. Gardner

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: William F. Gardner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 27, 1862

8. AGE: Years 83 | Months 1 | Days 6 | If less than one day hr. min.

9. Birthplace Manchester Md. (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Theodore S. Geiger
13. Birthplace Md.

MOTHER
14. Maiden Name Julia V. Beltz
15. Birthplace Md.

16 (a) Informant Mrs. Perley W. Clark
(b) Address Windsor Court Apts

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/6/45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cemetary
Location Pikesville, Md.

18 (a) Funeral director Wm. J. Tickner & Sons Inc
(b) Address North & Pa. Aves Huntingtor Williams, Md

19 (a) DEC 1 1945 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/3 19 45 at 2.22 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/16 19 45 to 12/3 19 45
and that I last saw h e alive on 12/3 19 45

Immediate cause of death	Duration
Uremia	
Due to Generalized Arteriosclerosis	
Due to Ca of Lt Primary	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature L. H. DiElia Jr.
Address St Agnes Hosp Date signed 12/3/45 M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34763

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G34763 Registered No. 1396

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1130 N. Monroe
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) FULL NAME Harriet E. Ament

3 (b) If veteran, name war: None

3 (c) Social Security Account No. None

4. Sex: Female

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife: George F.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 9-1878

8. AGE: Years	Months	Days	If less than one day
67	7	22	hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: William Fulton
13. Birthplace: Unknown

MOTHER
14. Maiden Name: Not Known
15. Birthplace

16 (a) Informant: Mr. George F. Ament
(b) Address: 1130 N. Monroe St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/4/45 (month) (day) (year)
(c) Cemetery or crematory: Cedar Hill
Location: Annapolis Blvd.

18 (a) Funeral director: William J. Tickner & Sons
(b) Address: North & Pa. Aves.

19 (a) [illegible] (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-1-45 19 at 4:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-17-1945 to 12-1 1945. and that I last saw her alive on 12-1 19 45.

Immediate cause of death: Respiratory Failure — Duration

Due to: Pulmonary Embolism — over

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C H Frye, Jr M. D.
Address Maryland General Hosp. Date signed 12-1-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634764

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √83a

634764 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3655 Gelston Drive
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3655 Gelston Drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charlotte Henkelman

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Mathias A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 3, 1852

8. AGE: Years	Months	Days	If less than one day
93	11	0	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John G. Wunder
13. Birthplace Germany

MOTHER
14. Maiden Name Sophie Wunder
15. Birthplace Germany

16 (a) Informant Mrs. Helen Hayes
(b) Address 3655 Gelston Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 5, 1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Wm. J. Toikner & Sons, Inc.
(b) Address North & Pa. Aves.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION A

20. DATE OF DEATH December 3, 1945, at 6:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 27, 1945 to Dec. 3 1945, and that I last saw her alive on Dec. 2, 1945

Immediate cause of death	Duration
Cerebral hemorrhage & paralysis	6 da
Due to Arteriosclerosis & Hypertension	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hallie E. Abbott M. D.
Address 2220 Harrison Date signed Dec 4/45

VS 150

634765

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 1243 — 634765

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1540 Pennsylvania Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1540 Pennsylvania Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lasnie Butler

3 (b) If veteran, name war WW I

3 (c) Social Security Account No. 217-03-8435

4. Sex male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1899

8. AGE: Years	Months	Days	If less than one day
46			hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Porter

11. Industry or business

FATHER
12. Name James Butler
13. Birthplace Md

MOTHER
14. Maiden Name Lena Craige
15. Birthplace Md.

16 (a) Informant Thomas Butler
(b) Address 1149 N. Carey St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location Md.

18 (a) Funeral director Rev. A. Kelly
(b) Address 303 Pressman St.

19 (Date received by registrar) DEC 4 - 1945 Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 2, 1945, at 10 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Portal cirrhosis, marked
Rupture of Esophageal varices
Due to

Other Conditions Confluement lobular
Pneumonia, bilateral
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury, M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

Signature Benedict Stolarelic, M.D.
Medical Examiner.
Date signed 12-3-45

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634766

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 178a

634766 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto. Gen. Hospital 21
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-0-4
(e) Length of stay in Baltimore (yrs., mos., or days) 57

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 935 Ridgely St. 2nd floor
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** John M. Fort

3 (b) If veteran, name war —

3 (c) Social Security Account No. NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	WIDOWED

6 (b) Name of husband or wife LUCY D.
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) DEC. 7, 1869

8. AGE: Years	Months	Days	If less than one day
75	76	11	26	hr. min.

9. Birthplace TROY, N.Y.
(Town, county, and state)
10. Usual Occupation PAINTER (RETIRED)
11. Industry or business

FATHER
12. Name JOHN. M. FORT, SR.
13. Birthplace TROY, N.Y.

MOTHER
14. Maiden Name MARGARET P.
15. Birthplace TROY, N.Y.

16 (a) Informant MRS. BERTIE M. FRANEY
(b) Address 4926 PENMORE AVE.

17 (a) BURIAL (b) Date thereof DEC 5, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory WESTERN CEMETERY
Location EDMONDSON AVE.

18 (a) Funeral director Walter Burke Bradley
(b) Address 1922 W. North Ave.

19 (a) 12/4/45 Huntington Williams, Registrar
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-3- 1945, at 7 noon M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation

Due to Illuminating Gas

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-3-45 at A.M.
(b) Where did injury occur? 935 Ridgely St: 3rd floor
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? —
(d) Means of injury Unlit gas jet - kitchen range.

23. Signature Howard J. Williams M.D.
Medical Examiner.
Date signed 12-3-45.

128

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634767

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 44a

Registered No. 634767

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3020 Barclay St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 - 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3020 Barclay St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph John Coppinger

3 (b) If veteran, name war —

3 (c) Social Security Account No. 220-14-8545

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Married

6 (b) Name of husband or wife Cecilia Coppinger
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7 / 1890

8. AGE: Years	Months	Days	If less than one day
55	4	7.	hr. min.

9. Birthplace Ireland
(Town, county, and state)
10. Usual Occupation Farmer Engineer
11. Industry or business

FATHER
12. Name Wm Coppinger
13. Birthplace Ireland

MOTHER
14. Maiden Name Margie Carr
15. Birthplace Ireland

16 (a) Informant Mrs J J Coppinger
(b) Address 3020 Barclay St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/5/45 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location 4th & Seguard Rd

18 (a) Funeral director J. J. Tobey & Son
(b) Address 13 W Lexington St.

DEC 4 - 1945 (Date rec'd by Registrar) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 2 1945, at 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1945 to Dec 2 1945 and that I last saw h him alive on Dec 1 1945.

Immediate cause of death	Duration
Coronary occlusion	36 hours
Due to arteriosclerosis.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Egbert H. Wortemis Jr M. D.
Address 2704 St Paul Date signed

X Wortemis Dec 3-45

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634768

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 634768

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 2101 W Cold Spring La
(b) Street address ~~Forest Park~~
(c) Hospital or institution: Cold Spring Lane Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Bowleys Rd Middle River
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Gail

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Mary Gail
6 (c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) 2/25/1868

8. AGE: Years	Months	Days	If less than one day
77	9	7	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Painter
11. Industry or business Retired

FATHER
12. Name George Gail
13. Birthplace Germany

MOTHER
14. Maiden Name Louise Scherer
15. Birthplace Germany

16 (a) Informant Mary Gail
(b) Address Bowleys Rd Middle River

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 5th (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans St

19 DEC 4 - 1945 (Date rec'd by local reg.) (b) Huntington Willenbrink, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 2 1945 at 3:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 23 1945 to Dec 2 1945, and that I last saw h[illegible] alive on Nov 26 1945

Immediate cause of death	Duration
cerebral hemorrhage	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. N. Cutterman M. D.
Address 2324 Reisterstown Rd Date signed 12/3/45

VS 150

X

634769

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓57E

Registered No. 634769

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 203 N Lakewood ave
(c) Hospital or institution: Maryland General Hospital 6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 4
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 203 N Lakewood ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mr. Milton Kraft

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Freda Kraft
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) July 3 1888

8. AGE: Years 57 | Months 5 | Days — | If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Guard

11. Industry or business Franklin Bowling Alley

FATHER
12. Name Martin Kraft
13. Birthplace Germany

MOTHER
14. Maiden Name Christine Stenge
15. Birthplace Germany

16 (a) Informant Freda Kraft
(b) Address 203 N Lakewood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 6 45 (month) (day) (year)

(c) Cemetery or crematory Baltimore Cem Cemetery
Location

18 (a) Funeral director Sellers & Funeral Home
(b) Address Pres & Allegheny Sts

19 (a) DEC 4 1945 (Date rec'd by registrar) Registrar for Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 6 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-31 1945, to 12-3 1945, and that I last saw him alive on 12-3 1945.

Immediate cause of death	Duration
Respiratory Failure	
Due to Mediastinal tumor	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: mass in mediastinum

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas Bruce Jr

Address Maryland Gen Hosp Date signed 12/3/45 M.D.

G34770

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 54a

G34770 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address REDWOOD AND GREENE STS
(c) Hospital or institution:
UNIVERSITY HOSPITOL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State W.VA (b) County HAMPSHIRE
(c) City or town GREEN SPRING (RURAL)
(If outside city or town limits, write RURAL and give town)
(d) Street No. ✓ (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Linda Bradfield

3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	CHILD

6 (b) Name of husband or wife ✓
6 (c) If alive, give age ✓ years

7. Birth date of deceased (mo., day, yr.) JUNE 6. 1942

8. AGE: Years	Months	Days	If less than one day
3	5	27	hr. min.

9. Birthplace CHICAGO Ill COOK ASHLAND AVE (Town, county, and state)
10. Usual Occupation CHILD
11. Industry or business —

FATHER
12. Name CLAUDE BRADFIELD
13. Birthplace MOREFIELD W VA.

MOTHER
14. Maiden Name MARY DEURR
15. Birthplace CUMBERLAND MD.

16 (a) Informant Mary P. Bradfield
(b) Address GREEN SPRING. W.VA.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12/6/45 (month) (day) (year)
(c) Cemetery or crematory FOREST GLENN
Location GREEN SPRING W.VA. (RURAL)

18 (a) Funeral director Ralph N Guthrie
(b) Address Romney W. Va

DEC 4 1945 (b) Huntington W. Va.
(Date received by Registrar)

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/3 1945, at 4:35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/25 1945 to 12/3 1945, and that I last saw h. alive on 12/3 1945.

Immediate cause of death	Duration
medullary edema	1 hr
Due to operative trauma	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 12/3/45
Major findings of operation: astrocytoma brainstem
of autopsy: same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John P Doenges
Address University Hosp Date signed 12/3/45

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634771
AB-97556

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X 161c

Registered No. 634771

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.
(e) Length of stay in Baltimore (yrs., mos., or days) 1 hr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Annapolis
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1 Cypress Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henrietta Young

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: C

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 27-1945

8. AGE: Years | Months | Days: 1 | If less than one day: 2 hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ? Young
13. Birthplace ?

MOTHER
14. Maiden Name Kane Johnson
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals' Records
(b) Address 4940 Eastern Ave.

17 (a) Cremated (Burial, cremation, or removal) (b) Date thereof 11-30-45 9 Am (month) (day) (year)
(c) [redacted] crematory Baltimore City Hospitals
Location 4940 Eastern Ave.

18 (a) Funeral director
(b) Address

DEC 4 - 1945 (Date received by registrar) Huntington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 28- 1945, at 9.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-28 1945, to 11-28 1945, and that I last saw h er alive on 11-28-45 1945.

Immediate cause of death Hemorrhage duodenal — Duration 1 day

Due to unknown

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: ? erythroblastosis fetalis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature walter M Tevis M. D.

Address BCH Date signed 12/1/45

X

G34772

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 117a

G34772 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline & Oliver Sts.
(c) Hospital or institution: St. Joseph's Hosp. 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12/2/45; 1:45 P.M. to 2:45 P.M.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1812 Bank St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a). FULL NAME Mr. James J. Phillips (JAWORSKI)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-90

8. AGE: Years	Months	Days	If less than one day
55.			hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation Engeneer

11. Industry or business Coca Cola Co. Fort Ave

FATHER
12. Name Nicholas Jaworski
13. Birthplace Poland.

MOTHER
14. Maiden Name Rozalia Horska
15. Birthplace Poland.

16 (a) Informant Anna Tyszkiewicz
(b) Address 7202, Lakewood

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-6-45 (month) (day) (year)

(c) Cemetery or crematory Holy Rosary
Location Balto., Md.

18 (a) Funeral director Wm. S. Fialkowski
(b) Address 2007 Eastern Ave

DEC 4 1945 (Date rec'd by registrar) (b) Huntingtown Williamsport MD

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/2 1945 at 2.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/2 1945 to 12/2 1945 and that I last saw him alive on 12/2 1945.

Immediate cause of death Toxiema.
Generalized Peritonitis
Due to Ruptured Gastric Ulcer.
Due to
Other Conditions Bacillary Pneumonia
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Ruptured Gastric Ulcer Bacillary Pneumonia

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John T. Everett
Address St. Josephs. Date signed M. 12 D. 2/45

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34773

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 53

G34773 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital, Balto., Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 32 days
(e) Length of stay in Baltimore (yrs., mos., or days) 32 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Tenn. (b) County
(c) City or town Memphis
(If outside city or town limits, write RURAL and give town)
(d) Street No. 283 Adams St.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Lee Thomas Hensley

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widowed

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 10, 1898

8. AGE: Years	Months	Days	If less than one day
47	10	21	hr. min.

9. Birthplace Ashland, Miss. (Town, county, and state)
10. Usual Occupation striker
11. Industry or business seafaring

FATHER
12. Name Wiley B. Hensley
13. Birthplace Ashland, Miss.

MOTHER
14. Maiden Name Mollie Jergen
15. Birthplace Ashland, Miss.

16 (a) Informant Records
(b) Address U. S. Marine Hospital, Balto. Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 5 45 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cemetery
Location York Rd.
18 (a) Funeral director Acker Funeral Home Inc.
(b) Address 4644 York Rd.
19 (a) (b) (Date rec'd by registrar) DEC 4 - 1945 Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 1 1945 at 8:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 30 1945, to Dec. 1 1945, and that I last saw him alive on Dec. 1 1945.

Immediate cause of death	Duration
Malignant melanoma with extensive metastasis to lungs and liver.	3 months
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John L. Wilson M.D.
John L. Wilson, Sr. Surgeon
Address Clinical Director Date signed 12/4/45
U. S. Marine Hospital, Balto., Md

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34774

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G34774
Registered No.

BD #97010

1313

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 1 21
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1009 Denver St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Charles Hopkins

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-07-7118

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Elizabeth
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4, 1917.

8. AGE: Years	Months	Days	If less than one day
28	4	28	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation LABORER.
11. Industry or business BETHLEHEM STEEL CO.

FATHER
12. Name Samuel Hopkins
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name MARY McElwee?
15. Birthplace BALTIMORE, MD.

16 (a) Informant Baltimore City Hospitals Records
(b) Address 4940 Eastern Ave.

17 (a) BURIAL (b) Date thereof 12-5-45.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory WESTERN CEM.
Location EDMONDSON AVE.

18 (a) Funeral director Charles S. Zeiler
(b) Address 3605 Fait Ave.

19 (a) DEC 4 - 1945
(Registered by registrar)
Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 2, 1945, at 7:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 31, 1945, to Dec. 2, 1945, and that I last saw h[illegible] alive on Dec. 2, 1945.

Immediate cause of death: Pulmonary Tuberculosis — Duration: 2.
Due to
Due to
Other Conditions Cor Pulmonale
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy: Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Herbert B. Copeland Jr.
Address Balt. City Hosp. Date signed 12/5/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634775

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. 634775

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 758 Dolphin St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17-3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 758 Dolphin St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Julia Ann Smothers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Col.	Widowed

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-28-1853

8. AGE: Years	Months	Days	If less than one day
91	11	4	hr. min.

9. Birthplace Bukittsville, Md. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Bernard Howard
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah Brown
15. Birthplace Md.

16 (a) Informant Lucy Smothers
(b) Address 758 Dolphin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-4-45 (month) (day) (year)
(c) Cemetery or crematory Petersville, Md
Location
18 (a) Funeral director Elwy O Wilson
(b) Address 1000 Brantley
(c) DEC 4 - 1945 (Date rec'd by registrar) (b) Registrar Huntington Williams, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 2 1945 at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 5 1945 to Dec 2 1945, and that I last saw h. alive on Dec 1 1945

Immediate cause of death Bronchopneumonia — Duration 4 days

Due to Age.

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(c) Means of injury —

23. Signature R. B. Wharton M. D.
Address 827 N. Charles Date signed 12/3/45

X

G34776

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G34776 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: John Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1224 St. Matthew St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Luke McNair

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife 1897

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1897

8. AGE: Years 48 | Months | Days | If less than one day hr. min.

9. Birthplace N.C. (Town, county, and state)

10. Usual Occupation Labor

11. Industry or business

FATHER 12. Name Barney McNair
13. Birthplace N.C.

MOTHER 14. Maiden Name Nancy McNair
15. Birthplace N.C.

16 (a) Informant Mrs Annie McNair
(b) Address 1204 St Matthews St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec (month) (day) (year)
(c) Cemetery or crematory Clayton N.C.
Location N.C.

18 (a) Funeral director Chas O Wilson
(b) Address 1001 Pratt St.

19 (Date received by registrar) DEC 4 1937 Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/3 1937, at 1:05 A.M.

21. I certify that I took charge of the remains described above, held an Inspection-Inquest thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Pelmiski M.D.
Medical Examiner.
Date signed 12/3/37

G34777

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G34777

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1945 N. Patterson Park Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 1/2
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1945 N. Patterson Pk Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Alvina B. Schaefer
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Fem	White	Widowed

6 (b) Name of husband or wife John N. Schaefer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/13/70

8. AGE: Years	Months	Days	If less than one day
75	8	16	hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation at Home
11. Industry or business

FATHER
12. Name Peter Quirk
13. Birthplace Germany

MOTHER
14. Maiden Name Louise Boessler
15. Birthplace Germany

16 (a) Informant Mrs. John Eichman
(b) Address 1945 N. Patterson Pk. Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/6/45 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto., Md.

18 (a) Funeral director Lassahn Funeral Home
(b) Address 3300 Belair Rd.

19 (a) DEC 4 - 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 3rd 1945, at 1.40 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from October 7 1944 to December 3 1945, and that I last saw her alive on Dec. 3 1945.

	Duration
Immediate cause of death Congestive heart failure	4 days
Due to Chronic myocarditis	3 yrs
Due to	
Other Conditions Chronic cholecystitis	unknown

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Bertha Lafaman Shamer
Address 3300 W. North Ave. Date signed M. 12 D. 4/45

VS 150

G34778

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH V171C

Registered No. G34778

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town N
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4 York Rd - Md Line
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME John Jones

3 (b) If veteran, name war.....

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1901

8. AGE: Years	Months	Days	If less than one day
44			..... hr. ..... min.

9. Birthplace.....
(Town, county, and state)

10. Usual Occupation.....

11. Industry or business

FATHER
12. Name.....
13. Birthplace

MOTHER
14. Maiden Name.....
15. Birthplace

16 (a) Informant.....
(b) Address

17 (a)..... (b) Date thereof.....
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location

University Medical School NOV 30 1945
Commissioner of Health

18 (a) Funeral director.....
(b) Address.....

19 DEC 4 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 21, 1945, at 11 A. M

21. I certify that I took charge of the remains described above, held an Partial Autopsy Autopsy, Inspection or Inquiry thereon, and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Hen. death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Skull Fracture

Due to.....

Other Conditions Fract. 3, 4, 5, 6, 7, 8 and 9 ribs. Fract. of left tibia and fibula.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-18-45 at 8:20 P. M.
(b) Where did injury occur? York Rd. 90' north of intersection of York Road and Md. Line.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Ped. struck by auto.

23. Signature Benedict Skotarlic M.D.
Medical Examiner.
Date signed.....

VS 151

3115

63479 DEAN

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 63479

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 637 Washington Blvd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 637 Washington Blvd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Deaw

3 (b) If veteran, name war or service 1st World War. | 3 (c) Social Security Account No. —

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age X years

7. Birth date of deceased (mo., day, yr.) Dec 1 - 1869

8. AGE: Years 76 | Months | Days | If less than one day hr. min.

9. Birthplace Burmingham England
(Town, county, and state)

10. Usual Occupation Retired U.S. Army

11. Industry or business

FATHER
12. Name George Deaw
13. Birthplace Birmingham Eng.

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Andrew Menges
(b) Address 637 Washington Blvd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 6 1945 (month) (day) (year)

(c) Cemetery or ~~cemetery~~ Loudon Park National
Location Frederick Rd.

18 (a) Funeral director Charles W. Kirchhausen
(b) Address 637 Washington Blvd

19 (a) DEC 4 1945 (Date received by local registrar) (b) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 1, 1945 at 10:30 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 12-1-45

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634780

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. 634780

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2826 Harford Avenue
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2826 Harford Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN LEYBURN ASTWOOD

3 (b) If veteran, name war: No

3 (c) Social Security Account No. no

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Anna Amelia Astwood

6 (c) If alive, give age: 54 years

7. Birth date of deceased (mo., day, yr.): Feb. 12, 1882

8. AGE: Years: 63 | Months: 10 | Days: 20 | If less than one day: hr. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation: Candy Salesman

11. Industry or business:

FATHER
12. Name: John Henry Astwood
13. Birthplace: Bermuda

MOTHER
14. Maiden Name: Mary Dunscombe
15. Birthplace: Bermuda

16 (a) Informant: Mrs. Anna Astwood
(b) Address: 2826 Harford Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-5-45 (month) (day) (year)
(c) Cemetery or crematory: Mt. Carmel Cemetery
Location: Baltimore, Maryland

18 (a) Funeral director: HENRY SANDER & SONS, INC.
(b) Address: NORTH AVE. & BROADWAY

19 DEC 4 - 1945 (Date rec'd by Local Reg.) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION P. M.

20. DATE OF DEATH Dec. 2 1945 at 5.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1- 1945 to Dec 2 1945, and that I last saw h.. alive on Dec 2 1945

Immediate cause of death: Malignant Hypertension Stenosis Cerebral Hemorrhage

Due to: Arteriosclerosis Hypertension

Due to: Chronic Interstitial Nephritis

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration
2 days
2 days
2 days
2 d
2 Dy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: F A Stevens M. D.

Address 2478 Harford Av Date signed 12-3-45

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34781

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 1576

G34781 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N CAROLINE ST.
(c) Hospital or institution: ST JOSEPH'S HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 23 MONTHS

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County BALTO
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2120 BOUNDARY AVE (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME NANCY N WARREN (NANCY NORA WARREN)

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: SINGLE
6 (b) Name of husband or wife:
6 (c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.) Dec 29 1943
8. AGE: Years 1 | Months 23 | Days 26 | If less than one day hr. min.
9. Birthplace BALTIMORE MARYLAND (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name LEON WARREN
13. Birthplace North Carolina

MOTHER
14. Maiden Name NORA WARREN
15. Birthplace North Carolina

16 (a) Informant Mr. Leon Warren
(b) Address 2130 Boundary Avenue -6

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-5-45 (month) (day) (year)
(c) Cemetery or crematory First Evangelical Cem.
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

DEC 4 - 1945 (Date rec'd by Registrar) (b) Huntington Williamsport

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 Dec 1945 at 4:13 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 2 Dec 1945 to 3 Dec 1945; and that I last saw h OV alive on 3 Dec 1945.

Immediate cause of death CARDIO-RESPIRATORY FAILURE DUE TO BRONCHOPNEUMONIA — Duration 2 days
Due to
Due to
Other Conditions CONGENITAL HEART FAILURE (Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: NOT PERFORMED

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury —

23. Signature C Raeburn W Martin M.D.
Address St Joseph's Hosp Date signed 3 Dec 1945

VS 150

107

G34782

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

Registered No. G34782

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; the correct age in especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3314 Cheeley Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 5
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3314 Cheeley Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Chester Arthur Yost

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Divorced

6 (b) Name of husband or wife Caroline
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 31 - 1896

8. AGE: Years	Months	Days	If less than one day: hr.	min.
59	4	4		

9. Birthplace New Martinsville W. Va.
(Town, county, and state)
10. Usual Occupation Steel Worker
11. Industry or business Book Steel Co.

FATHER
12. Name Christian Yost
13. Birthplace Ohio

MOTHER
14. Maiden Name Caroline Grad
15. Birthplace Ohio

16 (a) Informant Mrs. Laurence Powell
(b) Address 3314 Cheeley Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-6-45 (month) (day) (year)
(c) Cemetery or crematory W. Va.
Location New Martinsville

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Rd.

19 (a) (Date received by Registrar) DEC 4 1945 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 4, 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 17 1945 to 26 Nov 1945 and that I last saw him alive on 26 Nov. 1945

Immediate cause of death: (a) PULMONARY edema
(b) cardiac decompensation — Duration: 40 days
Due to (c) ARTERIOSCLEROTIC heart disease, MITRAL INSUFFICIENCY — 4 years
Due to (d) CHRONIC passive CONGESTION of LIVER — 4 years
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert J. Glass, M.D.
Address 826 Wash. Blvd. Date signed 4 Dec 1945

X

634783

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

Registered No. 634783

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2202 Mt. Holly St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 9
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2202 Mt. Holly St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Bertha W. Cohee

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Harvey G. Cohee
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 5,1877

8. AGE: Years	Months	Days	If less than one day
68	2	28	hr. min.

9. Birthplace Hobbs, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name William Holbrook
13. Birthplace Augusta, Maine

MOTHER
14. Maiden Name Miranda Callaway
15. Birthplace Maryland

16 (a) Informant Mrs. Reginia Shaw
(b) Address 2202 Mt. Holly St.

17 (a) Burial (b) Date thereof Dec. 5,1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemetery
Location Woodlawn, Md.

18 (a) Funeral director Miles Lawrence
(b) Address 4510 Liberty Heights Ave.

19 Date rec'd by local reg. DEC 4 - 1945 (b) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH December 3 1945, at 8.25A M

21. I certify that death occurred on the date above stated; that I attended deceased from August 1943 to Dec 3 1945 and that I last saw h. alive on 12/3/45 19

Immediate cause of death	Duration
Uremia	
Due to Adeno carcinoma of Breast with	
Due to multiple Metastasis to Brain, liver, other breast etc	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Howland Applegarth M. D.
Address 2511 Reisterstown Rd Date signed

VS 150

634784

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered 634784

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful... correct age is especially important. Physicians: please write the... the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Madison + Linden

(c) Hospital or institution: Maryland General 15

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1825 N. Whitmore Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) **FULL NAME** Sophie Preston Sophie Catherine Preston

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Divorced

6 (b) Name of husband or wife Wallace U. Davis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 17, 1878

8. AGE: Years	Months	Days	If less than one day
67	3	16	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER

12. Name Michael Preston

13. Birthplace Germany

MOTHER

14. Maiden Name Anna M. VonWeber

15. Birthplace Germany

16 (a) Informant Miss A. Margaret Bedient

(b) Address 1825 Whitmore Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 7, 1945 (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cemetery

Location Baltimore, Md.

18 (a) Funeral director Miller Lamoreaux

(b) Address 4515 Liberty Heights Ave.

19 (a) DEC 4 - 1945 (Date received by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/2 1945, at 3:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/2 1945 to 12/3 1945 and that I last saw her alive on 12/3 1945

Immediate cause of death Pulmonary Edema — Duration 24 hrs

Due to Arteriosclerotic C.V. Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Martin E. Strubel M. D.

Address Md. Gen. Hospital Date signed 12/3/45

X

34785

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 34785

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital 20

(d) Length of stay in hospital or inst. (yrs., mos., or days) Dos

(e) Length of stay in Baltimore (yrs., mos., or days) 32 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 24 N. Monastery Ave. (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country —

3 (a) FULL NAME Albert E. Stecher

3 (b) If veteran, name war None

3 (c) Social Security Account No. 150-10-0082

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Margaret C. Stecher

6 (c) If dead, give age years

7. Birth date of deceased (mo., day, yr.) May 30, 1884

8. AGE: Years 61 | Months 6 | Days 3 | If less than one day hr. min.

9. Birthplace Rochester N. Y. (Town, county, and state)

10. Usual Occupation Lithographer

11. Industry or business Federal Tin Co.

FATHER
12. Name Unknown
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Margaret C. Stecher
(b) Address 24 N. Monastery Ave

17 (a) Burial (b) Date thereof Dec. 5, 1945
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory St. Pauls
Location Violetville, Md.

18 (a) Funeral director Geo. L. Schwab
(b) Address 2201 Frederick Ave.

DEC 4 - 1945 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 2, 1945, at 11:53 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushed Head

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 20/7
(a) Date of injury 12-2-45 at 11:53 P. M.
(b) Where did injury occur? Monastery Avenue near St. Joseph St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
Means of injury Struck by bus while alighting from another bus

23. Signature Robert Lee Keating M.D.
Medical Examiner.
Date signed Dec 3 1945

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34786

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

Registered No. G34786

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRINT WITH PENCIL, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2829 Roselawn Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2829 Roselawn Aveme (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sophie Madeline Rose

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: John Henry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 15,1858

8. AGE: Years 87 | Months 8 | Days 18 | If less than one day: hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Unknown Wagner
13. Birthplace Germany

MOTHER
14. Maiden Name Katherine Kauffman
15. Birthplace Germany

16 (a) Informant Mrs. Lillian Sindall
(b) Address 4626 Pimlico Road

17 (a) burial (Burial, cremation, or removal) (b) Date thereof Dec6, 1945 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn, Maryland

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul Street

19 DEC 5 - 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 3, 1945 at 9:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 20 1944 to Dec 3 1945 and that I last saw her alive on Dec 1 1945

Immediate cause of death: Cardiac Decompensation — Duration: Nov 27 1945

Due to:

Due to:

Other Conditions: Chronic Myocarditis (Arterio-Sclerosis) — A number of years

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature Morris B. Green M. D.
Address 3009 Evergreen Ave Baltimore 14 Maryland Date signed Dec 4/45

G34787
JL - 96511

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. 634787

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 49 40 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 - 27
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3513 Edmondson Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Woods Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Mary E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 3, (1874) 1873

8. AGE: Years	Months	Days	If less than one day
(71) 72	1	0	hr. min.

9. Birthplace Balto, Md.
(Town, county, and state)
10. Usual Occupation Retired Police Officer
11. Industry or business

FATHER
12. Name William Johnson
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth Jumper
15. Birthplace Penna.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/7/45 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director Nylhorn Co. Inc
(b) Address 1217 E. Fort Ave.

19 (a) 12-5-1945 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 3, 1945, 6.00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 6, 1945, to Dec. 3 1945, and that I last saw him alive on Dec. 3 1945.

Immediate cause of death Cardiac Failure — Duration
Due to arteriosclerotic heart Disease
Due to
Other Conditions Tabo-paresis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: none
of autopsy: Cardiac failure

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature T. P. Jerrigan M. D.
Address Baltimore City Hosp Date signed 12-4-45

937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34788

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G34788

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 - 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1815 Guilford Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Ra. Fleur.

3 (b) If veteran, name war	3 (c) Social Security Account No.
W	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Charles E
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-20-1870

8. AGE: Years	Months	Days	If less than one day
75	5	13	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George S. Robinson
13. Birthplace Md.

MOTHER
14. Maiden Name Laura Collins
15. Birthplace Anne Arundel Co. Md.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 12/6/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Westown Md

18 (a) Funeral director Tallom & Cook Inc
(b) Address 1217 E Pont St

19 (a) Date received DEC 5 1945 (b) Registrar
Acting for Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec - 3 1945, at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec - 3 1945 to Dec - 3 1945 and that I last saw him alive on Dec - 3 1945

Immediate cause of death: Cerebral Hemorrhage — Duration: 8 hrs
Due to: Hypertensive Cardio Vascular Disease — 10 y/s
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Laura Buchan M.D.
Address Johns Hopkins Hosp
Date signed 12/3/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634789

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55B

Registered No. 634789

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 913 Mackubin Court
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 913 Mackubin Court (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Elliott Combs Hammond

3 (b) If veteran, name war None | 3 (c) Social Security Account No. None

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Wallace Hammond

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 21. 1887

8. AGE: Years 57 | Months 11 | Days 12 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Thomas McCarter

15. Birthplace Baltimore Md

MOTHER 14. Maiden Name Mary Combs

15. Birthplace Montgomery City Mo

16 (a) Informant Ruth Rand

(b) Address 913 Mackubin Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory Green Mount

Location Baltimore Md

18 (a) Funeral director Tilhom Bros

(b) Address 2121 E Fort Ave

19 (a) DEC 5 - 1945 (Date rec'd by registrar) (b) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 3 1945, at 7P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1945 to Dec 1945, and that I last saw her alive on Dec 1 1945.

Immediate cause of death Sarcoma. — Duration 2 yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 1944

Major findings of operation: Biopsy Sarcoma

of autopsy:

over

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harold Burns M. D.

Address 5H Med Arts Date signed 12/5/45

VS 150

G34790

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 102

Registered No. G34790

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 133 N. Potomac Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 133 N. Potomac Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Neals P. Sorensen

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	214-01-8838

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Louise
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 1, 1876

8. AGE: Years	Months	Days	If less than one day
69	1	2	hr. min.

9. Birthplace Denmark (Town, county, and state)
10. Usual Occupation Foreman
11. Industry or business Canton Company

FATHER
12. Name Unknown
13. Birthplace Denmark

MOTHER
14. Maiden Name Unknown
15. Birthplace Denmark

16 (a) Informant Mrs. Louise Sorensen,
(b) Address 133 N. Potomac Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 6, 1945 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Baltimore Co. Maryland

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) DEC 1945 (Date received by Registrar) (b) Huntington for Nicholas, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 3 1945, at 5:55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 7 1945 to Dec 3 1945 and that I last saw h[illegible] alive on Dec. 3 1945

Immediate cause of death	Duration
Cardiac Dilatation	
Pulmonary oedema	Hours
Due to Hypertension	3 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation: none
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide none
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature B. F. Kelly M. D.
Address 100 N Linwood Ave Date signed Dec 4/45

VS 150

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34791

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 937

G34791 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1620 N. Caroline Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1620 N Carolina St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William T. McGlone

3 (b) If veteran, name war: W
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife Catherine
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 8 1867

8. AGE: Years 78 | Months 1 | Days 26 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Retired Cattle
11. Industry or business Livestock Auctioneer

FATHER
12. Name Thomas McGlone
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Margaret Reard
15. Birthplace Baltimore Md

16 (a) Informant Robert McGlone
(b) Address 1620 N Carolina St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/9/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Wilson Colt Inc
(b) Address 1217 E Fort Ave

DEC 5 - 1945 (Date rec'd by registrar) Hattie Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 4, 1945, at 2 35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-18, 1945 to 12-4 1945. and that I last saw him alive on 12-4, 1945.

	Duration
Immediate cause of death: Myocardial Insufficiency	1 Day
Due to: chronic myocardial sclerotic insufficiency	indef.
Due to: Gen. arteriosclerosis	indef.
Other Conditions: Chronic arthritis deformans	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Myron V. Boyko, M.D.
Address 1626 N. Caroline St. Date signed 12-4-1945.

VS 150

X

G34792

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G34792 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 943 Ottawa Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME FANNY BURTON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race Col.

6 (a) Single, married, widowed, or divorced. widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 17, 1880

8. AGE: Years 65 | Months 10 | Days 6 | If less than one day ..... hr. ..... min. 16

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Laundress

11. Industry or business

FATHER
12. Name Walter Burton
13. Birthplace Va.

MOTHER
14. Maiden Name Hannah Johnson
15. Birthplace Va.

16 (a) Informant Sarah Walker
(b) Address 64 W. 133rd St. N.Y.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-6-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

19 (a) ..... (Date rec'd by registrar) (b) ..... Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/2/45 19..., at 7:15 PM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis, M.D. Medical Examiner.
Date signed 12/3/45

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634793

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164E

634793 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp. ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 Wks.
(e) Length of stay in Baltimore (yrs., mos., or days) 17 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 539 W. West St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Mercer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Theodosia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 22, 1909

8. AGE: Years 36 | Months 2 | Days 8 | If less than one day hr. min.

9. Birthplace Barbara, N.C. (Town, county, and state)

10. Usual Occupation Barber

11. Industry or business

FATHER
12. Name Joseph Mercer
13. Birthplace N.C.

MOTHER
14. Maiden Name Anna Porter
15. Birthplace N.C.

16 (a) Informant James Mercer
(b) Address 620 S. Fremont

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 5-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director James A. Sayers
(b) Address 1142 W. Hill St

19 (a) (Date received by registrar) (b) Registrar

VS DEC 5 - 1945 Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-30-1945 at 3:20 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy + Insp. thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured skull

Due to

Other Conditions Fractured scapulae, lacerations etc.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11/28/45 at 4:40 P.M.
(b) Where did injury occur? 539 W. West St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no
(d) Means of injury Jumped from window.

23. Signature Howard J. Theodosis M.D. Medical Examiner.
Date signed 11-30-45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634794

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 H

634794 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greenspring + Belvedere Aves
(c) Hospital or institution: Levindale Hebrew Home + Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5428 Park Heights Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jessie Poliakoff

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1905

8. AGE: Years	Months	Days	If less than one day
40	6		hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER
12. Name Rabbi Abraham Jacob Poliakoff
13. Birthplace Russia

MOTHER
14. Maiden Name Ida ?
15. Birthplace Russia

16 (a) Informant Sarah Poliakoff
(b) Address 5428 Parkheights Ave

17 (a) Burial (b) Date thereof December 5, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cemetery
Location Hamilton Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) (b)
Date received by Local Registrar DEC 5 1945 Huntington Williams, MD Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 4 1945, at 5.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-22 1945, to 12-4 1945, and that I last saw h[illegible] alive on 12-4 1945.

Immediate cause of death Retroperitoneal sarcoma of pelvis. — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence 1945 at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H Edmund Shere

Address Levindale Date signed 12/7/45

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34795

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52a

Registered No. G34795

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 629 N. Lakewood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 629 N. Lakewood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry L Enright

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-01-3508

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 3rd 1878

8. AGE: Years 67 | Months 5 | Days - | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Shipping Clerk

11. Industry or business Butler Bros

FATHER 12. Name Charles Enright

13. Birthplace Md

MOTHER 14. Maiden Name

15. Birthplace Md

16 (a) Informant Mrs. Edward Enright

(b) Address 629 N. Lakewood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 7th 1945 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Belgian Road

18 (a) Funeral director Leo G. Leach

(b) Address 1701-03 N Patterson Park Ave

DEC 5 - 1945 (Date rec'd by registrar) Huntington Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 3rd 1945, at 9.50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 8 1945, to Dec 3rd 1945; and that I last saw h~~im~~er alive on Dec 3rd 1945.

Immediate cause of death	Duration
Metastasis in brain Surg.	2 m
Due to carcinoma of left Kidney	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. J. Jenkins M. D.

Address 100 N Milton Date signed 12/5/45

vs 1800 Dr Jenkins 100 N Milton Ave

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634796

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

634796 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette Ave.
(c) Hospital or institution Bon Secour Hospt.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) 32 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1917 W. Lexington St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Patrick J. Mullin

3 (b) If veteran, name war —
3 (c) Social Security Account No. 705-07-6391

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	M

6 (b) Name of husband or wife Agnes T.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 23. 1889

8. AGE: Years	Months	Days	If less than one day: hr.	min.
56	9	10		

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation Boiler maker
11. Industry or business B & O R.R.

FATHER
12. Name John Mullin
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Hare
15. Birthplace Ireland

16 (a) Informant Mrs Agnes T. Mullin
(b) Address 1917 W Lexington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/6/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Rd

18 (a) Funeral director John J. Bowman Son
(b) Address 901-03 Hollins St.

19 (a) (Date rec'd by registrar) (b) Registrar

DEC 5 - 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/3/1945 at 10-15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/21/1945 to 12/3/1945 and that I last saw him alive on 12/3/1945

Immediate cause of death	Duration
Cerebral-Vascular Accident	
Due to Essential Hypertension	12 days
Due to Bronchial Pneumonia	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thos. Norton, Jr. M.D.
Address Bon Secours Hosp Date signed 12/3/45

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634797

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. 34292

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 229 N Luzerne
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balt
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 229 N Luzerne
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary J McClintock

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife William Clintock

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec 22 - 1866

8. AGE: Years 78 | Months 11 | Days 13 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation

11. Industry or business At Home

FATHER
12. Name James Harrison
13. Birthplace Balto

MOTHER
14. Maiden Name Anna Pryor
15. Birthplace Balto

16 (a) Informant Wm J McClintock
(b) Address 300 Westfield Ave

17 (a) Burial (b) Date thereof Dec 7th
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Baltimore Cem
Location City

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2005 Aliceanna St

19 (a) DEC 5 1945 (b) Huntington Williams, M.D.
(Date rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 4th 1945, at 11:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 1943 to Dec 4, 1945 and that I last saw h alive on Dec 4 1945

Immediate cause of death EMBOLISM
Cerebral Embolism
anterior cerebri — Duration: 1 Day

Due to CHR. INT. NEPH. — 2 yrs

Due to Chr. Int. Hyp. — 16 mo.

Other Conditions Embolism of Lt Foot — 1 Day

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James F Cavanaugh M.D.
M. D.
Address 3328 McElderry St Date signed 12-5-45

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634798

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 162 B

Registered No. 634798

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2304 Aiken Street
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 d
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2304 Aiken St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sophia Schaake

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Wm. A. Schaake
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 8, 1867

8. AGE: Years	Months	Days	If less than one day
78	11	26	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Adam Hildwein
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Hoffman
15. Birthplace Germany

16 (a) Informant Mrs. Wm. H. Marshall
(b) Address 2304 Aiken St,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 6/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel Cem.
Location Balto. Md.

18 (a) Funeral director Philip Henry Sons
(b) Address 2024 Orleans St.

Dec 5 1945 (Date rec'd by Registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH (Month) Dec. (Day) 4th (Year) 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw her alive on Dec. 3 1945.

Immediate cause of death	Duration
Impaction 1 day	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. Ferry Carman M. D.
Address 1701 N. Caroline Date signed Dec 5-45

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634799

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13a

634799 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 419 N. Wallas St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) 58 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 419 N. Wallas St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maude James

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race C. | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Andrew N. James
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 2 1884

8. AGE: Years 61 | Months 2 | Days 3. | If less than one day hr. min.

9. Birthplace Cambridge Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Eugene Hill
13. Birthplace Md.

MOTHER 14. Maiden Name Mary McGlotlin
15. Birthplace Md.

16 (a) Informant Rita Brown
(b) Address 419 N. Wallas St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 5 - 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Balto. Co. Md.

18 (a) Funeral director Thomas F. Wright
(b) Address 721 Presquile St

19 (a) Dec 5 1945 (b) Registrar Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 2nd 1945 at 3.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6-5- 1945 to 12-2- 1945.
And that I last saw him alive on 12-1- 1945.

Immediate cause of death Cardio-Renal Disease — Duration

Due to

Due to

Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. H. Conyers M. D.
Address 611 N. Caroline Date signed 12-4-45

VS 150

634800 — BALTIMORE CITY HEALTH DEPARTMENT — 634800

CERTIFICATE OF DEATH 163H

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or Inst. (yrs., mos., or days) Died
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1321 W. Fayette St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME (Edwin S Brooks) Edwin Spencer Brooks

3 (b) If veteran, name war: —

3 (c) Social Security Account No. 215-09-0968

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Bertie

6 (c) If alive, give age 34 years

7. Birth date of deceased (mo., day, yr.) June 5 1915

8. AGE: Years (30) 30 | Months 5 | Days 28 | If less than one day ... hr. ... min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business Mfg Co

FATHER — 12. Name John C. Brooks

13. Birthplace Md

MOTHER — 14. Maiden Name Rose E. Brass

15. Birthplace Md

16 (a) Informant Bertie Brooks

(b) Address 1321 W Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 5 1945 (month) (day) (year)

(c) Cemetery or crematory Mt Olivet Cem

Location Balto City

18 (a) Funeral director Pott & B. M. Walter

(b) Address Pratt & Stricker Sts

19 (a) Dec 5 1945 (b) Huntington Williams MD

(Date received by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/3 1945, at 2:45 A.M.

21. I certify that I took charge of the remains described above, held an Inquest-Jury thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Asphyxia due to illuminating gas

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 12/3/45 at about 1:45 P.M.

(b) Where did injury occur? 1321 W. Fayette St

(c) Did injury occur at home, on farm, industrial place, in public place? at home While at work? No

(d) Means of injury Turned on gas heater

23. Signature P. J. Sullivan M.D. Medical Examiner.

Date signed 12/3/45

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important. Any supplies. The

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6.34801

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

6.34801 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Harford Rd & Herring Run
(c) Hospital or institution: Sydenham Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 406 S. Stricker St.
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME James E. Johnson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 27, 1945

8. AGE: Years 0 | Months 5 | Days 7 | If less than one day ....hr. ....min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business —

FATHER
12. Name Thomas Leland Johnson
13. Birthplace Virginia

MOTHER
14. Maiden Name Ethel Marie
15. Birthplace Baltimore

16 (a) Informant Mother
(b) Address 406 S Stricker

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 5-1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Park City
Location Lot C, B.M. Walter

18 (a) Funeral director Pratt & Stricker
(b) Address Pratt & Stricker

19 (a) DEC 5 - 1945 (b) (Registered by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 5 1945, at 11:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 26 1945 to Dec 5 1945, and that I last saw him alive on Dec 5 1945.

	Duration
Immediate cause of death Pneumonia	
Intracerebral Pressure	
Due to Influenza meningitis	10 days
Due to	
Other Conditions Pertussis, bronchopneumonia, otitis media, eczema, malnutrition (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy: ✓

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ....at ....M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Melchijah Spragins M. D.
Address Sydenham Hosp. Date signed 12-4-45

VS 150

Huntington Williams, M.D.

33B

634802

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

634802
Registered No.

THESE WHITE SPACES, WITH UNFADING INK. Every item or information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1417 Longwood.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 7

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County Balto Md
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1417 Longwood ST
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Johanne Stafford Tiebart
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	Widowed

6 (b) Name of husband or wife August Tiebart
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 22 1856

8. AGE: Years	Months	Days	If less than one day
89	4	10	hr. min.

9. Birthplace Germany
(Town, county and state)
10. Usual Occupation Domestic
11. Industry or business House work

FATHER
12. Name Gerhard Stafford
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Buckholz
15. Birthplace Germany

16 (a) Informant Anna Eppig
(b) Address 22 Forest Avenue

17 (a) Burial (b) Date thereof 12/5/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lundenwald Park
Location Balto City

18 (a) Funeral director Edward McNabb
(b) Address Catonsville Md

19 (a) (b) Huntington Williams M.D.
(Date received by Registrar)

DEC 3 1945
VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 2, 1945, at 2.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1 1945, to Dec. 2 1945, and that I last saw h.. alive on Dec. 2 1945.

Immediate cause of death	Duration
Chronic Myocarditis	1 Yr;
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature H. C. Williams
Address 2257 W Mont. Date signed 12/4/45

X

G34803

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G34803 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert St.
(c) Hospital or institution:
Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 1

2. USUAL RESIDENCE OF DECEASED: Harford
(a) State Md. (b) County Balt.
(c) City or town Baltimore & Bel Air
(If outside city or town limits, write RURAL and give town)
(d) Street No. 33rd & Calvert St. (U.M.H.) 136 Maulsby Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Sechrist

3 (b) If veteran, name war 0
3 (c) Social Security Account No. 0

4. Sex M. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Single.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12 4 45

8. AGE: Years 0 | Months 0 | Days 01 | If less than one day 20 hr. 22 min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation 0

11. Industry or business 0

FATHER 12. Name Mr. Charles J. Sechrist.
13. Birthplace Md.

MOTHER 14. Maiden Name Mrs. Charles J. Sechrist
15. Birthplace Md.

16 (a) Informant Mr. Charles J. Sechrist
(b) Address 136 Maulsby Ave, Bel Air.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Dec 5-45 (month) (day) (year)
(c) Cemetery or crematory Quigley Penna
Location York Co Pennsylvania

18 (a) Funeral director Wm Cook Inc.
(b) Address 217 St Paul St. Balto Md

19 (a) DEC 5 - 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 5 1945, at 7 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/4/45 19 to 12/5/45 19, and that I last saw him alive on 12/5/45 19.

	Duration
Immediate cause of death: Cardio-Resp. Failure	
Due to: Asphyxia Neonatorum.	25 hrs.
Due to: Prematurity - (Wt. 5 lbs 2 ozs)	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation /
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. W. Hodges M.D.
(Res. Physician) M. D.
Address Union Mem. Hospital Date signed 12/5/45

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634804

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 634804

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2216 Jefferson St
(c) Hospital or institution: 7-3

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2216 Jefferson St (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph J. Valis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Emma Valis

6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) June 27 1879

8. AGE: Years 66 | Months 5 | Days 6 | If less than one day ....hr. ....min.

9. Birthplace Bohemia (Town, county, and state)

10. Usual Occupation Insurance Clerk

11. Industry or business

FATHER
12. Name John Valis
13. Birthplace Bohemia

MOTHER
14. Maiden Name Emma Jedounka
15. Birthplace Bohemia

16 (a) Informant Emma Valis
(b) Address 2216 Jefferson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-5-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto. Md.

18 (a) Funeral director Mack Brooks Son
(b) Address 900 N. Chester St

19 (a) DEC 5 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 3 1945, at 11:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 5 19 45, to Dec 3 1945 and that I last saw h alive on Dec 2 1945.

Immediate cause of death Coronary Thrombosis — Duration 1 day

Due to

Due to Coronary

Other Conditions Sclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature]

Address 900 N Chester St Date signed 12-5-45

VS 150

634805

BALTIMORE CITY HEALTH DEPARTMENT

AB-97662

CERTIFICATE OF DEATH

13B

Registered No. 634805

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 913 S. Decker Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME HENRY SCHRECK

3 (b) If veteran, name war: no
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife: Molly
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APR. 30 - 1892

8. AGE: Years	Months	Days	If less than one day
53	7	24	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name HENRY SCHRECK
13. Birthplace Md.

MOTHER
14. Maiden Name Louise Cordy
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals' Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 7/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location Edonnell st

18 (a) Funeral director Lilly & Zeiler Inc
(b) Address 403 S. Wolfe st

DEC 5 - 1945 (Date received by registrar) Huntington Williams M.D. (Signature of registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 4- 1945, at 12.40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-4- 1945 to 12-4 1945, and that I last saw h... alive on 12-4- 1945.

Immediate cause of death: Pulmonary edema — Duration: 1

Due to: Pulmonary tbc — Duration: 4

Due to — Duration:

Other Conditions — Duration:

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Pulmonary tbc & Cholemia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Margaret Downs M. D.
Address 4940 Eastern ave. Date signed 12-5-45

SUBJECT TO APPROVAL OF MEDICAL EXAMINER Benedict Retrachtland

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 63480

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2613 E Chase
(c) Hospital or institution: at home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2613 E Chase St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country –

3 (a) FULL NAME Carroll McAfee

3 (b) If veteran, name war ~~None~~

3 (c) Social Security Account No. 216-07-6607

4 Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Anna E McAfee

6 (c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) Aug. 20 1873

8. AGE: Years 72 | Months 3 | Days 14 | If less than one day: hr. min.

9. Birthplace Loch Haven Pa.
(Town, county, and state)

10. Usual Occupation Mgr Music Store

11. Industry or business Musical Supplies

FATHER 12. Name James McAfee

13. Birthplace Penna

MOTHER 14. Maiden Name Minnie Schied

15. Birthplace Germany

16 (a) Informant Mrs Anna E McAfee (wife)

(b) Address 2613 E Chase St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 6 45 (month) (day) (year)

(c) Cemetery or crematory Loch Haven

Location Loch Haven Pa.

18 (a) Funeral director Sheward Mowen Co.

(b) Address 108 W Mt Royal

19 (a) ... (b) Huntington Williams

(Date rec'd by registrar) DEC 5 – 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 4 1945, at 4:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 10 1945, to Dec 4 1945, and that I last saw h~~im~~ alive on Dec 4 1945.

Immediate cause of death – Cardio respiratory failure

Due to Coronary Thrombosis

Due to + Myocardial Infarction

Other Conditions General Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
2 mos.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Francis J Ayd

Address 2005 E Lexington St Date signed 12/4/45 (M. D.)

X

G34807

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

58 B

G-34807

Registered No. G34807

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 257 Robert ST
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 257 Robert ST (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Raymond Felix Wallace

3 (b) If veteran, name war

3 (c) Social Security Account No. 170-24-7601

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 6, 1928

8. AGE: Years 17 | Months 2 | Days 26 | If less than one day hr. min.

9. Birthplace Fremont, Ohio (Town, county, and state)

10. Usual Occupation Conveyor Operator

11. Industry or business

FATHER
12. Name Philip F. Wallace
13. Birthplace Mt Cuthbertville, Ohio

MOTHER
14. Maiden Name Josephine Allen
15. Birthplace Marion, Ohio

16 (a) Informant Josephine Wallace
(b) Address 257 Robert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 5, 1945 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk
Location Balto Co. Md.

18 (a) Funeral director Thos. Leo H. Hull
(b) Address 1631 Druid Hill Ave

DEC 5 - 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 2 1945, at 9 20 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Loss death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Rheumatic Endocarditis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed Dec 3 1945

correct age is especially important. Physicians: please write the causes of death clearly and legibly. The cause or circumstances around of carefully supplied. The

VS 151

X

G34803

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 168

G34803 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important. Use only black ink. Do not use any symbols.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 23
(c) Hospital or institution: South Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 45 West West St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Randolph

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 6 1907

8. AGE: Years 37 | Months 11 | Days 29 | If less than one day hr. min.

9. Birthplace Maker Georgia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Dorothy Elizabeth Thomas
(b) Address 45 West St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-7-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Cedar Hill Md.

18 (a) Funeral director Hopkins Hubstead
(b) Address 918 Druid Hill Ave.

19 (a) (Date received by registrar) DEC 5 1945 (b) Hunting for Witness

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 4, 1945, at 8 10 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured skull

Due to

Other Conditions Multiple lacerations, brain bruise & abrasion

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8 P.M. 12-4-45
(b) Where did injury occur? In front of 111 W. Montgomery St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Blunt force

23. Signature Howard J. Messeis M.D. Medical Examiner.
Date signed 12-5-45

X

634809

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

634809 Registered No. 133 B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address University Hosp
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4400 Arabia Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles P. Schlag

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Pearl Schlag
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) Mar. 19. 1878

8. AGE: Years	Months	Days	If less than one day
67	8	15	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Customs Officer Inspector
11. Industry or business U.S. Govt

FATHER
12. Name Adam Schlag.
13. Birthplace Md.

MOTHER
14. Maiden Name Caroline
15. Birthplace

16 (a) Informant Pearl Schlag
(b) Address 4400 Arabia Ave

17 (a) Burial (b) Date thereof Dec 7, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Ave

18 (a) Funeral director Mrs. Mrs. John H. Feifel & Son
(b) Address 308 W. Fayette st.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/4/45 19 , at 3:10 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 30 1945, to Dec 4 1945, and that I last saw h. alive on Dec 4 1945.

Immediate cause of death Anoxia	Duration
Due to Septic infarcts	
Due to Perineal Abscess	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James P. McHenry M. D.
Address Univ Hosp Date signed Dec 4 1945

Huntington Hillcrest

X

REGISTER WRITE PLAINLY, WITH UNFADING INK. Every item or information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634810 BALTIMORE CITY HEALTH DEPARTMENT 634810
CERTIFICATE OF DEATH 149a Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5701 Fair Oaks Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5701 Fair Oaks Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Nellie Tully Adams
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife George Adams
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 7-189[illegible]

8. AGE: Years 54 | Months 11 | Days 12 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation at Home

11. Industry or business

FATHER 12. Name ? Tully
13. Birthplace Md.

MOTHER 14. Maiden Name Anna Kelly
15. Birthplace Md.

16 (a) Informant Mrs. Gregory Companion
(b) Address 5701 Fair Oaks Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-7-45 (month) (day) (year)
(c) Cemetery or crematory Holy Red.
Location Balto.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Rd.

19 (a) (Date rec'd by registrar) DEC 8 1945 Henrietta Fox Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 3 1945, at 4:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 15 1945 to Dec 3 1945 and that I last saw h[illegible] alive on Dec 3 1945

Immediate cause of death Carcinoma of Left Ovary — Duration 1½ yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Nov 1945

Major findings of operation Carcinoma of Left Ovary

of autopsy: Yes

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence None at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury None

23. Signature K. L. Conley M.D. M.D.
Address 5706 Harford Rd. Date signed 12/6/45

Dr. Geo. Sybert
2802 Harford Road
G34811

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46F

Registered No. G34811

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2109 Kentucky Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2109 Kentucky Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Andrew Richwien

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	white	married

6 (b) Name of husband or wife Adah Louise
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 11, 1891

8. AGE: Years	Months	Days	If less than one day
54	--	22	hr. min.

9. Birthplace Washington, D.C.
(Town, county, and state)
10. Usual Occupation P. R. R. Clerk
11. Industry or business

FATHER
12. Name John A. Richwien
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth Heinz
15. Birthplace Md.

16 (a) Informant Mrs. Adah L. Richwien
(b) Address 2109 Kentucky Avenue

17 (a) Burial (b) Date thereof 12/5/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) DEC 5 1945 (b) Huntington Williams M.D. Registrar
(Registered by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 3 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1, 1945 to 12-3-1945, and that I last saw him alive on 11-30-1945.

Immediate cause of death Primary carcinoma of liver — Duration Terminal

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo. B. Sybert M. D.
Address 2802 Harford Rd Date signed 12-3-45

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34812 G34812

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1407 William St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1407 William St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Albert Berger Sr.

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Elizabeth Berger

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 18 1872

8. AGE: Years 73 Months 5 Days 15 If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name John N. Berger

13. Birthplace Baltimore

MOTHER 14. Maiden Name Isabella Ramsey

15. Birthplace Baltimore Md.

16 (a) Informant Mrs. Clara M. Hunt

(b) Address 1409 William St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-6-1945 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Baltimore Md.

18 (a) Funeral director Flynn & Flanigan

(b) Address 1426 Light St.

19 (a) (Date received by registrar) (b) Registrar

DEC 5 - 1945

Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 3 - 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from February 1940 to Dec 3 1945; and that I last saw h alive on Dec 2 1945.

Immediate cause of death Pulmonary Oedema — Duration 2 mo

Due to Chronic Endocarditis — 1 year

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature

Address 1779 Mulvane N Date signed 12/5/45 M. D.

X

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34813 G34813

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 93 D

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1820 Bolton St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1820 Bolton St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) **FULL NAME** Marie M. Watkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: John L. Watkins

6 (c) If alive, give age: 52 years

7. Birth date of deceased (mo., day, yr.): Sept. 3, 1890

8. AGE: Years: 55 | Months: 3 | Days: | If less than one day: hr. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation: housewife

11. Industry or business

FATHER
12. Name: Henry Miller
13. Birthplace: Germany

MOTHER
14. Maiden Name: Johanna Ackerman
15. Birthplace: Germany

16 (a) Informant: John L. Watkins
(b) Address: 1820 Bolton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Dec. 6, 1945 (month) (day) (year)
(c) Cemetery ~~or crematory~~: Druid Ridge
Location: Pikesville, Md.

18 (a) Funeral director: John O. Mitchell & Sons, Inc.
(b) Address: 1900 Eutaw Place

19 (a) DEC 5 - 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 3 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 2nd Dec 1945 to 3rd Dec 1945 and that I last saw h[illegible] alive on 3rd Dec 1945

Immediate cause of death: Acute Coronary Occlusion — Duration: 20 hrs.

Due to: Hypertensive Cardiovascular Disease — Duration: years.

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Laurence L. Kenny M.D.

Address: 1938 Linden Ave. Date signed: 3rd Dec 45

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34814

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. G34814

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2006 Wallbrook Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2006 Wallbrook Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eva C Moran

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife John H. Moran
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 20, 1867

8. AGE: Years	Months	Days	If less than one day
78	5	14	hr. min.

9. Birthplace St Marys Co., Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business "

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs. Lloyd Moran
(b) Address 3609 Haywards Ave

17 (a) Burial (b) Date thereof 12-6-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cemetery
Location Pikesville, Md

18 (a) Funeral director Lorna Byers
(b) Address 2345 Park Heights Ave

19 DEC 5 - 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 3 1945, at 9:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 28 1945, to Dec 3 1945, and that I last saw h er alive on Dec 2 1945.

Immediate cause of death	Duration
Coronary Thrombosis Heart Failure	5 days
Due to	
Due to Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Williams M. D.
Address 2344 Frederick Date signed 12/5/45

G34815

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

124a

Registered No. G34815

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days
(e) Length of stay in Baltimore (yrs., mos., or days) 43 Days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2021 Eastern ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leon S. Pinunski

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-9-05

8. AGE: Years	Months	Days	If less than one day
40	7	26	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Benjamin Pinunski
13. Birthplace ?

MOTHER
14. Maiden Name Dora Kijenski
15. Birthplace ?

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 12-7-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Balto. Co.

18 (a) Funeral director Wm. J. Fialkowski
(b) Address 2007 Eastern Ave

19 (a) DEC 5 - 1945 (b) Huntington Williams, M.D.
(Date rec'd by Local Reg.)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 4 1945, at 6:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/16/1945 to 12/4/1945. and that I last saw him alive on 12/4/1945.

Immediate cause of death cirrhosis, Laennec's

Duration
3 YEARS

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: NOT DONE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Grant Wilson M. D.
Address Johns Hopkins Hosp. Date signed 12/4/45

VS 150

634816

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

634816
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2562 Wilkins ave
(c) Hospital or institution: —

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 5
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2562 Wilkins ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Schlesinger

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Minnie Schlesinger
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov 25 1859

8. AGE: Years	Months	Days	If less than one day
86	8	9	—hr. —min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation —
11. Industry or business —

FATHER
12. Name George Schlesinger
13. Birthplace Germany

MOTHER
14. Maiden Name —
15. Birthplace Germany

16 (a) Informant John Schlesinger
(b) Address 2562 Wilkins ave

17 (a) Burial (b) Date thereof 12/5/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore Md

18 (a) Funeral director J. D. Shipley Son
(b) Address 15a W. Baltimore St

19 (a) (b)
(Date rec'd by registrar) Huntington Williams, Registrar
DEC 5-1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 3rd 1945, at 3a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 30 1945, to Dec 3 1945, and that I last saw h alive on Dec 3 1945.

Immediate cause of death Hypostatic Congestion
Cardio Vascular Renal Arteriosclerosis Chronic Nephritis
Due to Hypostatic
Due to Senility
Other Conditions Pulmonary Oedema

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Rachel C. Ricketts
Address 2562 Wilkins ave Date signed 12-7-45

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

482582 G34817 BALTIMORE CITY HEALTH DEPARTMENT G34817
CERTIFICATE OF DEATH 1119a Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1313 Ashland Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marcia Morsha Rowe (Marcia Elaine Rowe)
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Black
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 7-11-44
8. AGE: Years 1 | Months 4 | Days 22 | If less than one day hr. min.
9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business
FATHER 12. Name John Rowe.
FATHER 13. Birthplace N.Y.
MOTHER 14. Maiden Name Dairy Harris
MOTHER 15. Birthplace Md.
16 (a) Informant Reynolds.
(b) Address JOHNS HOPKINS HOSPITAL
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 6 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary.
Location
18 (a) Funeral director Robert L. Young
(b) Address 804 E. Carlisle St.
19 (a) (Date) registered (b) Registrar

DEC 5 1945 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec - 3 - 1945 at 9.45 M
21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 25 1945 to Dec-3 1945 and that I last saw h[illegible] alive on Dec-3 1945
Immediate cause of death Cardiac failure — Duration
Due to Interstitial myocarditis? — 5 wks
Due to
Other Conditions Regional ileitis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature J. W. Morrison, Jr. M. D.
Address Johns Hopkins Hosp. Date signed 12/5/45

X

634818

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. 634818

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1128 Ettinge st
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17

(e) Length of stay in Baltimore (yrs., mos., or days) 57 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Baltimore (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1128 Ettinge st
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Thomas Colbert

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widow

6 (b) Name of husband or wife Emma Lee Colbert

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 9th 1851

8. AGE: Years	Months	Days	If less than one day
94	3	24	hr. min.

9. Birthplace Honolulu Oa
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs William J. Colbert
(b) Address 1128 Ettinge st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/6/45 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn Cmty
Location Westport Md

18 (a) Funeral director George T. Gibson Sr
(b) Address 1735 Druid Hill Ave

19 (a) Dec 5 1945 (Signature of registrar) Huntington Williams, M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/3 1945, at 5 30 a.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 1945, to Dec 3 1945, and that I last saw h. alive on Sept 1945.

Immediate cause of death: Chr. Myocarditis + Senility — Duration 2 years

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. C. Stengler

Address 5111 N. Fremont Ave Date signed 12/4/45

X

634819

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

634819 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 11 E. Hamburg St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 11 E. Hamburg St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William L. Smith

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 217-03-3018

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Florence Galloway Smith

6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) Aug 12, 1879

8. AGE: Years 66 | Months 3 | Days 21 | If less than one day hr. min.

9. Birthplace Salisbury, Md.
(Town, county, and state)

10. Usual Occupation Foreman - Retired

11. Industry or business Bethlehem Fairfield

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mr. Albert A. Smith

(b) Address 847 Pontiac Ave.

17 (a) Burial (b) Date thereof 12/6/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Greenmount Cem
Annapolis Road, Md.

18 (a) Funeral director John J. Kenny Inc

(b) Address 714 Light St

DEC 5 1945 (Date received by Registrar) (b) Huntington Hollins Md.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/3rd 1945, at 9A M

21. I certify that I took charge of the remains described above, held an Autopsy / Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Howard J. Mercer M.D.
Medical Examiner.

Date signed 12-3-45

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

63130

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

Registered No. 63480

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4209 Arizona Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Crisfield Md (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** John Sherman Riggin

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Emma L. R.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 5 - 1887

8. AGE: Years 58 | Months 4 | Days 29 | If less than one day ... hr. ... min.

9. Birthplace Crisfield Md (town, county, and state)

10. Usual Occupation Oyster

11. Industry or business

FATHER 12. Name John D. Riggin
13. Birthplace Crisfield

MOTHER 14. Maiden Name
15. Birthplace Crisfield

16 (a) Informant Emma L. R. Riggin
(b) Address 4209 Arizona

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-6-45 (month) (day) (year)
(c) Cemetery or crematory Crisfield Cem.
Location Crisfield Md.

18 (a) Funeral director Frank V. Pepetone
(b) Address 815 E. Baltimore

19 (a) ... (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

DEC 5 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 3, 1945 19..., at 12.20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 15 1945 to Dec. 3 1945, and that I last saw him alive on Dec 3 1945

Immediate cause of death	Duration
CARCINOMA OF RECTUM	1 year.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation Feb, 1945

Major findings of operation: CARCINOMA OF RECTUM

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert J. Hunsefort M.D.
Address 1401 Eutaw Pl. Date signed 12/4/45

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34821

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

G34821 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-0A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 102 N. Dallas St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert Taylor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 22, 1900

8. AGE: Years	Months	Days	If less than one day
45	2	11	hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name unknown
13. Birthplace "

MOTHER
14. Maiden Name unknown
15. Birthplace "

16 (a) Informant Lida Cane
(b) Address 102 Dallas St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 6th (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy A. Wilson
(b) Address 1000 W. Pratt St.

19 Filed DEC 5 1945 (b) Registrar's signature Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-3- 1945, at 10:31 AM

21. I certify that I took charge of the remains described above, held an Inspection Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mellon M.D.
Medical Examiner.
Date signed 12-3-45

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G348626

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G348622 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 422 E. Biddle St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 422 E. Biddle St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HATTIE MAUDE NEWTON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife George H. Newton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 3, 1868

8. AGE: Years	Months	Days	If less than one day
77	4	1	hr. min.

9. Birthplace Yorkshire, N. Y.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Fleming King
13. Birthplace Yorkshire, N. Y.

MOTHER
14. Maiden Name Maniette Layton
15. Birthplace Yorkshire, N. Y.

16 (a) Informant Sallie Newton
(b) Address 422 E. Biddle St.

17 (a) Removal (b) Date thereof 12/5/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Hill Cem.
Location Fredericksburg, Va.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date received by registrar) (b) Registrar Huntington Williams, M.D.

DEC 5 - 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 4, 1945, at 5:40PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1 '45, to Dec. 4 '45, and that I last saw it alive on Dec. 4 1945.

Immediate cause of death: Apoplexy — Duration 4 days
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. L. Johnson M.D.
Address 403 Med Arts Bg Date signed 12-5-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G34823

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

G34823 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4726 Ivanhoe
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4726 Ivanhoe (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William B. Savin

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 31-1867

8. AGE: Years 78 | Months 6 | Days 4 | Less than one day hr. min.

9. Birthplace Balto. Co. Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Richard Savin

13. Birthplace Md.

MOTHER 14. Maiden Name Jane Cithen

15. Birthplace Balto Co. Md.

16 (a) Informant Mrs. Savin

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/6/45 (month) (day) (year)

(c) Cemetery or crematory Greenmount Cem. Location Balto. Co. Md.

18 (a) Funeral director John A. McCann 3000 E. Balto. St.

(b) Address

19 (a) (Date rec'd by Local Registrar) (b) Registrar

DEC 5 - 1945 Lexington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 4, 1945, at 5:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1, 1945 to Dec. 4, 1945; and that I last saw him alive on Dec. 4, 1945.

	Duration
Immediate cause of death Myocardial insufficiency	2 wks.
Due to	
Due to	
Other Conditions Hypotension	7

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature F. Willis Grayston, M. D.

Address 3963 Greenmount Ave. Date signed 12/5/45.

J. AHRENS & CO.
Funeral Directors 634824

BALTIMORE CITY HEALTH DEPARTMENT ✓ 634824
CERTIFICATE OF DEATH 46E Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address CALVERT & 33RD STS.
(c) Hospital or institution:
UNION MEMORIAL HOSPITAL 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County —
(c) City or town BALTIMORE 7
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1728 CARSWELL ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME [redacted] (BERTHA) STORTCH

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife EDWARD STORTCH

6 (c) If alive, give age 1 years

7. Birth date of deceased (mo., day, yr.) SEPT. 12, 1873

8. AGE: Years 72 | Months 2 | Days 22 | If less than one day — hr. — min.

9. Birthplace BALTIMORE, MD.
(Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business O

FATHER
12. Name ISAAC HECHT
13. Birthplace GERMANY

MOTHER
14. Maiden Name SOPHIE SCHLOSS
15. Birthplace GERMANY

16 (a) Informant HUSBAND
(b) Address 1728 CARSWELL ST.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 7/45 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship Cem.
Location Balto. Co. Md.

18 (a) Funeral director J. Ahrens & Co.
(b) Address 2432 Reisterstown Rd

19 (a) Date 1945 (b) — (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH DECEMBER 4, 1945 at 7:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 23, 1945 to Dec 4, 1945 and that I last saw her alive on Dec 4, 1945.

Immediate cause of death CARDIAC FAILURE — Duration —

Due to CA OF SIGMOID FLEXURE RUPTURE & ABDOMINAL

Due to ABCESS.

Other Conditions ARTERIOSCLEROSIS, GENERALIZED
(Include pregnancy within 3 months of death)

Date of operation Dec 1, 1945

Major findings of operation: CA OF SIGMOID FLEXURE RUPTURE

of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature C. C. Longlass M. D.
Address Union Memorial Hosp. Date signed 12/4/45

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G348235

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G348235 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Ave.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3617 Liberty Hgts. Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Giaraffa

3 (b) If veteran, name war: W

3 (c) Social Security Account No. 212-20-9649

4 Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Rosa Giaraffa

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) Feb 22nd 1882

8. AGE: Years 63 | Months 9 | Days 12 | If less than one day hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Shoemaker

FATHER
12. Name Petro Giaraffa
13. Birthplace Italy

MOTHER
14. Maiden Name Annetta Rimilli
15. Birthplace Italy

16 (a) Informant P. Nelson Giaraffa
(b) Address 3307 Gwynns Falls Parkway

17 (a) Burial (b) Date thereof 12/7/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 127 St. Paul St.

19 (a) (b) Williams, M.D. Registrar
(Signature of person acting for registrar)

DEC 6 - 1945 Huntington

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-4 1945 at 6 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/4 1945 to 12/4 1945, and that I last saw h/ alive on 12/4 1945.

Immediate cause of death: Cardiac failure — Duration

Due to Complete Heart Block

Due to Coronary Occlusion from Arteriosclerosis.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thos. E. Corr M.D.

Address St. Agnes Hosp Date signed 12/3/45

X

634826

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94A

634826

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2708 Hollins Ferry Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2708 Hollins Ferry Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Raymond V. Glann

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: none

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of ~~husband~~ wife: Amelia Glann
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 1878

8. AGE: Years: 67 | Months | Days | If less than one day: hr. min.

9. Birthplace: New York
(Town, county, and state)

10. Usual Occupation: Physician

11. Industry or business: Own Practice

FATHER
12. Name: Ray V. Glann
13. Birthplace: New York

MOTHER
14. Maiden Name: Amelia Henshaw
15. Birthplace: Balto. Md.

16 (a) Informant: Raymond Glann
(b) Address: 2708 Hollins Ferry Rd.

17 (a) Burial (Burial, ~~cremation~~, or removal) (b) Date thereof 12/8/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Moreland Park
Location: Parkville Md.

18 (a) Funeral director: William Cook Inc.
(b) Address: 1217 St Paul St.

19 (a) (Date received by Registrar) Registrar: Williams, M.F. Registrar

DEC 6 - 1945

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/4 1945, at 10:30 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to ~~his~~ death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. P. Habbinka M.D.
Medical Examiner.
Date signed 12/5/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634827

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93

Registered No. 634827

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkins & Caton Aves
(c) Hospital or institution:
St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1157 Cleveland St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr Caspar Reinhardt

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: none

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Mary Reinhardt
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Feb 21, 1867

8. AGE: Years 78 | Months 9 | Days 14 | If less than one day ____ hr. ____ min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Joseph Reinhardt
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Ai[illegible]
15. Birthplace Germany

16 (a) Informant Mr Anthony Reinhardt
(b) Address 3216 W. Baltimore St.

17 (a) Burial (b) Date thereof 12/10/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

19 (a) (Date rec'd by registrar) (b)
DEC 6 - 1945
Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/5 1945, at 8:50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/4 1945 to 12/5 1945, and that I last saw h[illegible] alive on 12/5 1945

Immediate cause of death	Duration
Acute Coronary Occlusion	
Due to Coronary - Sclerotic Cardio-	
Due to Vascular disease with Hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Curtlan T. Hall Jr. M. D.
Address St. Cyprs. Hosp. Date signed 12/5/45

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G348;28

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. G348;28

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 506 N. Carey St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) unknown

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 506 N. Carey St.
(Rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Wm. Pernell

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	colored	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1871

8. AGE: Years	Months	Days	If less than one day
74			hr. min.

9. Birthplace Greenbay Va
(Town, county, and state)

10. Usual Occupation Janitor
11. Industry or business Apartment House (Regular rent and Private family)

FATHER
12. Name unknown
13. Birthplace Greenbay Va

MOTHER
14. Maiden Name unknown
15. Birthplace Va

16 (a) Informant Mrs. Annabelle Carter
(b) Address 506 Carey St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 6-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

DEC 6 - Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-3-1945, at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-16-1945 to 12-3-1945, and that I last saw him alive on 12-2-1945.

Immediate cause of death	Duration
Gastric Carcinoma	unknown
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank A. Saunders M. D.
Address 029 N. Stricker St. Date signed 12-5-45

X

G34829

BALTIMORE CITY HEALTH DEPARTMENT ✓ G34829
CERTIFICATE OF DEATH 937
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 720 West Mulberry
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eliza Boyd (Boyce)

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Col.	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882 –

8. AGE: Years	Months	Days	If less than one day
63			hr. min.

9. Birthplace Blackstock, S.C.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Major Henry Beckham.
13. Birthplace Blackstock, S.C.

MOTHER
14. Maiden Name Emma Douglas
15. Birthplace Blackstock S.C.

16 (a) Informant Ruth Howard
(b) Address 647 George St.

17 (a) Burial (b) Date thereof Dec. 6 '45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St.
(c) DEC 6 1945 Huntington Williams, Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/2/45 19 , at 1:05 PM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio Vascular Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis, M.D.
Medical Examiner.
Date signed 12/2/45

VS 151

age is especially important. Physicians: please write the causes of death clearly and legibly.

634850

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 B (634850)

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Provident Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) d. o. a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1219 Division Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Phillip A. Dorsey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1897 - 6 - 22

8. AGE: Years: 48 | Months: 5 | Days: 10 | If less than one day: hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Stephen Dorsey
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Florence Sheppard
15. Birthplace Woodlawn Howard Co. Md.

16 (a) Informant Raymond Tighe
(b) Address 230 N. Arlington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 7 '45 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Lehmerd Ave

19 (a) DEC 6 - 1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 2, 19 45, at 6:40 P. M.

21. I certify that I took charge of the remains described above, held an Inspection + Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary tuberculosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skaltsadis M.D.
Medical Examiner.
Date signed December 2, 1945.

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34831

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 10

G34831

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Herring Run & Harford Rd.
(c) Hospital or institution: Lydenham Hosp. 5 days
(d) Length of stay in hospital or inst. (yrs., mos., or days) ~~5 days~~
(e) Length of stay in Baltimore (yrs., mos., or days) 2 8 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3334 Frederick Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Anita Papa

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced. Single
6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 12-29-42

8. AGE: Years 3 | Months 11 | Days 6 | If less than one day ... hr. ... min.

9. Birthplace New York City (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Joseph Papa
13. Birthplace Italy

MOTHER
14. Maiden Name Ann Mashinal
15. Birthplace Endicott, N. Y.

16 (a) Informant Mr. Joseph Papa
(b) Address 3334 Frederick Ave

17 (a) Burial (b) Date thereof 12-6-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore Md.

18 (a) Funeral director Geo. L. Beyer Jr.
(b) Address 1512 Hollins St.

19 (a) ... (b) ... Registrar
(Date rec'd by registrar)

DEC 6 - 1945

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 5 1945, at 5 15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1 1945, to Dec. 5 1945, and that I last saw her alive on Dec. 5 1945

Immediate cause of death	Duration
Complete Heart Block	
Due to Diphtheritic Myocarditis	
Due to Pharyngeal Diphtheria	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: ✓

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Adelaide Spagnuolo M.D.
Address Lydenham Hosp. Date signed 12-5-45

X

This is the second original death certificate issued. X ✓ G34832

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 940

Registered No. G34832

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Towson
(If outside city or town limits, write RURAL and give town)
(d) Street No. 308 Pennsylvania Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clara Smith

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	Widow

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-6-68

8. AGE: Years	Months	Days	If less than one day
77	5	25	hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Thos Watkins
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Rogers
15. Birthplace Md.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-6-1945 (month) (day) (year)
(c) Cemetery or crematory Pleasant Rest
Location Towson Md Balto Co

18 (a) Funeral director Byron & Mansfield Knight
(b) Address 721 Cathedral St

DEC 6 - 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION 55

20. DATE OF DEATH Dec. 1 1945, at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 16 1945 to Dec 1 1945, and that I last saw her alive on Dec 1 1945.

Immediate cause of death	Duration
Coronary Thrombosis	
Due to Arteriosclerosis	
the Coronary Arteries	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Coronary Thrombosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Freeman T. Stephens M. D.
Address Johns Hopkins Hospital Date signed 12/1/45

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34833

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G34833

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) D. of A
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 543 W. Lafayette Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Delia Love

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C.	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-24-1892

8. AGE: Years	Months	Days	If less than one day
52	11	9	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name Enoch Plater
13. Birthplace Maryland

MOTHER
14. Maiden Name Carrie Robinson
15. Birthplace Maryland

16 (a) Informant Alfred Smallwood
(b) Address 126 N. Pearl Street

17 (a) Burial (b) Date thereof 12 7 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Arbutus Md.

18 (a) Funeral director William A. Jackson
(b) Address 916 Pennsylvania Ave

19 (a) (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

DEC 5 - 1945

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 3rd 1945, at 9 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Frates M.D.
Medical Examiner.
Date signed Dec 4 1945

B4834

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131 A

Registered No. 6348748

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1372 Whatcoat St
(c) Hospital or institution:
15
(d) Length of stay in hospital or inst. (yrs., mos., or days) none
(e) Length of stay in Baltimore (yrs., mos., or days) 35 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1372 Whatcoat St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Marion Cook

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Oliver Cook

6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) May 10 1890

8. AGE: Years 55 | Months 6 | Days 25 | If less than one day ... hr. — min.

9. Birthplace Calvert Co Md
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business own home

FATHER
12. Name John Wallace
13. Birthplace Calvert Co Md

MOTHER
14. Maiden Name Ann Adam
15. Birthplace Calvert Co. Md

16 (a) Informant John Wallace Jr.
(b) Address 1123 Whatcoat St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-9-45 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director George T. Nelson
(b) Address 1303 Presstman St

DEC 6 - 1945 (Date rec'd by Registrar) (b) Huntington Williams M.D.

VS 150.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-5 1945 at 6:5 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-10-1945 to 12-5-1945 and that I last saw her alive on 12-4-1945.

Immediate cause of death: Cerebral hemorrhage — Duration 55 days

Due to arteriosclerosis and hypertension

Due to

Other Conditions: Chronic Nephritis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jno. A. Secunder M. D.
Address 1029 N. Stricker St Date signed 12-6-45

X

634835

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

634835 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dor
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1523 E. Madison Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bernard Allen Harmon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 6, 1904

8. AGE: Years	Months	Days	If less than one day
41	8	27	hr. min.

9. Birthplace Princeton, W. Va. (Town, county, and state)

10. Usual Occupation

11. Industry or business Pig's Bakery

FATHER 12. Name William A. Harmon

13. Birthplace Virginia

MOTHER 14. Maiden Name Emma J. Davis

15. Birthplace W. Virginia

16 (a) Informant Geo. Ayler Pittsburgh

(b) Address 2nd St. - Princeton, W. Va.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 6, 1945 (month) (day) (year)

(c) Cemetery or crematory

Location Princeton, W. Va.

18 (a) Funeral director Geo. A. Hollan

(b) Address 1631 Druid Hill Ave

19 (a) (b) Huntington, Williams, W. Va. Registrar

DEC 6 - 1945

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 3, 1945, at 4:05 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Gunshot wound of head

Due to

Other Conditions Laceration of brain

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-3-45 at 4 P.M.
(b) Where did injury occur? On rear — 608 Hanover Alley
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No.
(d) Means of injury Gunshot wound of head

23. Signature Benedict Skotarek M.D.
Medical Examiner.
Date signed 12-3-45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634836 ✓ 634836

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Provident Hosp.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 521 N. Mosher St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Senora Peck

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Albert A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years 75 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name William Richardson
13. Birthplace Md.

MOTHER 14. Maiden Name Elizabeth Richardson
15. Birthplace Catonsville, Md.

16 (a) Informant Albert A. Peck
(b) Address 521 N. Mosher St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 6, 1945 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore Co. Md.

18 (a) Funeral director Mem. Bur. Ass. of Md.
(b) Address 1651 Druid Hill Ave

19 (a) DEC 6 1945 (Registered by) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 2, 1945, at 5 20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 5, 1945, to Dec 2 1945 and that I last saw h[illegible] alive on 12-2- 1945.

	Duration
Immediate cause of death: bronchopneumonia	36 hrs
Due to: congestive heart failure	1 wk
Due to: carcinoma of head of pancreas	9 mos
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
Signature James T. Carr M. D.
Address 515 Mosher St Date signed 12-6-45

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634837

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 87C

Registered No. 634837

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 W LEXINGTON ST
(c) Hospital or institution: Aged Men's & Women's Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1400 W Lexington St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Margaret Louise Fentz
3 (b) If veteran, name war —
3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 31 1875

8. AGE: Years	Months	Days	If less than one day
70	1	6	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name William H Fentz
13. Birthplace Unknown

MOTHER
14. Maiden Name Virginia Wilson
15. Birthplace Unknown

16 (a) Informant Mrs Thompson Nephew
(b) Address 1400 W Lexington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/7/45 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Baltimore Md

18 (a) Funeral director Wilson Cook Co
(b) Address 1214 E Fort Ave

DEC 6 1945 (b) Washington Nitkin

VS 150

MEDICAL CERTIFICATION A.

20. DATE OF DEATH 12/5/45 19 , at 7:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/29/1945 19 to 12/5/45 19 , and that I last saw her alive on 12/4/45 19 .

Immediate cause of death: Parkinson's Disease — Duration about 1 yr.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas B Jarrell M.D.
Address 11 E Chase St., City Date signed 12/5/45

G34838

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1721a

G34838
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 702 W. North Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nina Griffin

3 (b) If veteran, name war: No

3 (c) Social Security Account No.: None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 7- 1883

8. AGE: Years 62 | Months 10 | Days 28 | If less than one day hr. min.

9. Birthplace Howard Co- Md
(Town, county, and state)

10. Usual Occupation Cleak

11. Industry or busin Catholic Seminary House

FATHER
12. Name Samuel Griffin
13. Birthplace Maryland

MOTHER
14. Maiden Name Alethe Jenkins
15. Birthplace Maryland

16 (a) Informan Mrs A.W. Schaefer
(b) Address 702 W North St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 10-45 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location W. North Ave

18 (a) Funeral director Chas. T. Evans & Son
(b) Address 118 W. Mt. Royal Ave

DEC 6 - 1945 Huntington Williams M.D.
(Date rec'd by) (Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 5, 1945, at 6 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured skull

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-5-45 at 5:30 P. M. 11/2
(b) Where did injury occur? Charles St. 32' north of Lanvale St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Ped. Struck by streetcar

23. Signature Howard J. Uhlein M.D.
Medical Examiner.
Date signed 12-6-45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34839

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G34839 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3102 Wallbrook Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anna B. Muessen

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 213-14-5249

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Joseph W. Muessen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 15, 1894

8. AGE: Years 51 | Months 5 7 | Days 19 | If less than one day hr. min.

9. Birthplace: Balto., Md. (Town, county, and state)

10. Usual Occupation: Nurse

11. Industry or business: American Brake Shoe Co.

FATHER
12. Name: Herman Badenhoop, Sr.
13. Birthplace: Germany

MOTHER
14. Maiden Name: Laura A. Bieberbach
15. Birthplace: Germany

16 (a) Informant: Miss Hermine Badenhoop
(b) Address: 3310 Mondawmin Ave.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 12/7/45 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Baltimore, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) DEC 6 - 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 4, 1945, at 2 15 P.M

21. I certify that I took charge of the remains described above, held an Inquest (Autopsy / Inspection / Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Cerebral hemorrhage, spontaneous

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham, M.D. per Benedict Skotariello M.D. (Medical Examiner)
Date signed

63480

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

122B

63480 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette & Oliver Sts.
(c) Hospital or institution: St. Joseph's Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1642 Ralworth Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Philip Dearing

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/15/06

8. AGE: Years	Months	Days	If less than one day
39	6	19	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business B. & O. R. R.

FATHER
12. Name Henry Dearing
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Emma A. Lang
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Thelma L. Dearing
(b) Address 1642 Ralworth Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/8/45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

DEC 6 - 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/4 1945 at 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/1 1945 to 12/4 1945, and that I last saw him alive on 12/4 1945

Immediate cause of death: Post Operative Pneumonia Complication — Duration

Due to Intestinal Obstruction, Post Operative — Duration

Due to Cancer of Ileum — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation 12/2/45

Major findings of operation: Obstruction of Ileum by Cancer

of autopsy: Pneumonia - Bronchial

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John T. Farrell M. D.
Address St. Joseph Hosp. Date signed 12/4/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634841

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 B

634841 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2929 Arunah Ave.
(c) Hospital or institution: 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2929 Arunah Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME RAYMOND F. URBUS

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	219-01-4324

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Louise H. Urbus
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 24, 1920

8. AGE: Years	Months	Days	If less than one day
25	7	11	hr. min.

9. Birthplace Balto. Maryland
(Town, county, and state)
10. Usual Occupation Merchandizer
11. Industry or business Montgomery Ward & Co.

FATHER
12. Name Frank Urbus
13. Birthplace Lith.

MOTHER
14. Maiden Name Rose Ozell
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Louise H. Urbus
(b) Address 2929 Arunah Ave.

17 (a) Burial (b) Date thereof 12/8/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

DEC 6 1945 (b) [illegible] M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 5, 1945, at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/27 1945 to 12/5 1945 and that I last saw h[illegible] alive on Nov. 24 1945.

Immediate cause of death: Foraminous Pulm Tub — Duration 1-2 yrs
Due to: Tuberculous Laryngitis — few mos
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Alex A. Weinstock M.D.
Address 4603 Kitola Ave Date signed 12/6/45

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

34842

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

34842 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3952 Penhurst Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 11 Years.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3952 Penhurst Ave.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MAX GREENEBAUM.

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-09-4741.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 8, 1898.

8. AGE: Years	Months	Days	If less than one day
47	4	27	hr. min.

9. Birthplace Germany. (Town, county, and state)
10. Usual Occupation Retired Dental Technician.
11. Industry or business

FATHER
12. Name Herman Greenebaum,
13. Birthplace Germany.

MOTHER
14. Maiden Name Martha Kaufman,
15. Birthplace Germany.

16 (a) Informant Mr. Henry Greenebaum,
(b) Address 3952 Penhurst Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12.7.45. (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location Balto. Md.

18 (a) Funeral director Edward Sonneborn & Son
(b) Address 1902 Eutaw Place.

19 (a) DEC 6 1945 (Date received by Registrar) (b) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 5th. 19 45 at 12:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1942 19 to 12/5 19 45, and that I last saw him alive on 12/3/45 19

Immediate cause of death: Cerebral coronary thrombosis — Duration: 3 yrs.
Due to: coronary arteriosclerosis
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel Brown, M.D.
Address 2904 Reisterstown Rd. Date signed 12/6/45

X

G34813 — BALTIMORE CITY HEALTH DEPARTMENT — G34813

CERTIFICATE OF DEATH 1310

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 318 E. 22 1/2 St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 1 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 318 E 22 1/2 St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mattie Jenkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Col	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 15/1898

8. AGE: Years	Months	Days	If less than one day
47	1.	18	hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER — 12. Name Josh Jenkins
13. Birthplace Va

MOTHER — 14. Maiden Name Louise Jenkins
15. Birthplace Va

16 (a) Informant Mollie Robinson
(b) Address 318 E. 22 1/2 St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-6-45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. a. Co

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St

19 (a) 12-6-1945 (b) Registered by Washington Williams, M.D. Registrar
VS 1st

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 3 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 10 1945 to Dec 3 1945 and that I last saw h. alive on Dec 3 1945

Immediate cause of death Cardiac Renal Disease — Duration 6 mos

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dr. A. Robinson M. D.
Address 2329 Guilford Date signed Dec 4 1945

X

G34844 G34844

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 178 Q Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 626 S. Bond St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Peter Orth

3 (b) If veteran, name war: 1st World War.

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: Single

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 14, 1888.

8. AGE: Years 57 56 | Months 5 | Days 26 | If less than one day hr. min.

9. Birthplace Austria
(Town, county, and state)

10. Usual Occupation Band. Saw & Cutter

11. Industry or business League Lumber Co

FATHER
12. Name Joseph Orth
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Kryener
15. Birthplace Austria

16 (a) Informant Otto Orth
(b) Address 917 S. Potomac St

17 (a) Burial (b) Date thereof Dec 7 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory H.S. National
Location Frederick Co. Md.

18 (a) Funeral director Kendel Hoppe
(b) Address 312 S. Highland Ave

19 (a) DEC 6 1945 (b)
(Date received by local registrar)

VS 151

Huntington for Millington, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/3 1945, at 8:10 P M

21. I certify that I took charge of the remains described above, held an Inspection-Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxia due to Illuminating Gas

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12/3/45 at about 8:00 A.M.
(b) Where did injury occur? 626 S. Bond St
(c) Did injury occur at home, on farm, industrial place, in public place? at home While at work? No
Building of 926 Floor
(d) Means of injury Gas Jet

23. Signature B. J. Sulinski M.D.
Medical Examiner.
Date signed 12/3/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G348:5 G348:5

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2815 Woodbrook Ave
(c) Hospital or institution:

13

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2815 Woodbrook Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Herman Schoen

3 (b) If veteran, name war

3 (c) Social Security Account No. 234-05-2619

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace Austria
(Town, county, and state)

10. Usual Occupation
11. Industry or business Salesman

FATHER
12. Name Max Schoen
13. Birthplace Austria

MOTHER
14. Maiden Name Yetta Finkelstein
15. Birthplace Austria

16 (a) Informant Louis Schoen
(b) Address 2815 Woodbrook Ave

17 (a) Burial (b) Date thereof December 7, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship Cem
Location 2600 E Baltimore St

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W Month Ave

19 (a) DEC 6 - 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION 9.10

20. DATE OF DEATH December 5 1945 at P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 5 1945 to Dec 5 1945, and that I last saw him alive on Dec 5 1945.

Immediate cause of death	Duration
Acute Coronary Thrombosis	a few minutes
Due to Chr. Arterio sclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
1945 Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. W. Kearns M.D.
Address 1938 Linden Ave Date signed 12/6/45

VS 180

For Dr. J. R. Davis, by Howard J. Mendis, M.D.

G34816

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 107

Registered No. G34816

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1721 N. Appleton St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Tucker ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 17 1945

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Nathan Tucker
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Emma Hyman
15. Birthplace Baltimore

16 (a) Informant Nathan Tucker
(b) Address 1721 N. Appleton St

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location Destroyed by Hospital

18 (a) Funeral director
(b) Address

DEC. 6 - 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 18, 1945 at 8:24 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19
and that I last saw h alive on 19

Immediate cause of death	Duration
Meconium ileus,	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Edwin Jameson M. D.
Address Sinai Hosp. Date signed 12-5-45

VS 3

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item or information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34847 BALTIMORE CITY HEALTH DEPARTMENT 55E G34847
CERTIFICATE OF DEATH Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 33
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Harford
(c) City or town Aberdeen (If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Margaret Elizabeth Cullum
3 (b) If veteran, name war
3 (c) Social Security Account No.
4 Sex female
5. Color or race W
6 (a) Single, married, widowed, or divorced. (M)
6 (b) Name of husband Luther C. Cullum
6 (c) If alive, give age 29 years
7. Birth date of deceased (mo., day, yr.) Jan 4-1920
8. AGE: Years 25 Months 10 11 Days 27 If less than one day hr. min.
9. Birthplace Aberdeen Md (Town, county and state)
10. Usual Occupation Housewife
11. Industry or business
FATHER 12. Name John Monksdale
13. Birthplace Harford Co. Md.
MOTHER 14. Maiden Name Elsie Culbert
15. Birthplace Harford Co Md
16 (a) Informant Mrs. Luther C. Cullum
(b) Address Aberdeen Md
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 9-19 45 (month) (day) (year)
(c) Cemetery or crematory Calvary
Location Creswell Harford Co.
18 (a) Funeral director Harvey Fanning Funeral
(b) Address Aberdeen Md
19 DEC 6 - 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-5-45 19 ; at 2.55 P M
21. I certify that death occurred on the date above stated; that I attended deceased from 11-3 1945, to 12-5 1945, and that I last saw h-- alive on 12-5 19 45
Immediate cause of death Respiratory failure — Duration
Due to Melano Sarcoma
Due to in Right inguinal region
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation Same
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature G. J. Boyce Jr M. D.
Address M G H Date signed 12-5-45

VS 160 Huntington Williams, M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

63488 — BALTIMORE CITY HEALTH DEPARTMENT — 63488

CERTIFICATE OF DEATH 83a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 706½ W. Saratoga
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) 52 60

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 706½ W. Saratoga
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Henry McCray

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col	married

6 (b) Name of husband or wife Maggie McCray
6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) Mar - 25 1887

8. AGE: Years	Months	Days	If less than one day
58	8	12	hr. min.

9. Birthplace Seaford Delaware
(Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business Curtis Bay Arsenal

FATHER
12. Name James Ed McCray
13. Birthplace Seaford - Del

MOTHER
14. Maiden Name Mary C Hopkins
15. Birthplace Seaford Del

16 (a) Informant Bertha McCray
(b) Address 706½ W Saratoga St

17 (a) Burial (b) Date thereof 12/7/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location

18 (a) Funeral director Walter B. Sprigg
(b) Address 139 W. Hamburg St.

19 DEC 6 - 1945 Huntington Williams M.D.
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec - 3 1945 at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov - 23 1945 to Dec. 3 1945, and that I last saw h alive on Dec 3 1945

Immediate cause of death Coronal Thrombosis

Due to Hypertension Nephritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration
13 Days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dan Trautlein
Address Lynn Sea Date signed 12/6/45 M. D.

VS 150

2676553849

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

63a

Registered No. 63489 (Grey)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1513 E. Fayette St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Moody

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male

5. Color or race: Black

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Estelle Moody

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 16, 1894

8. AGE: Years 51 | Months 6 | Days | If less than one day hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Records -
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/6/45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvery
Location Elroy O. Wilson

18 (a) Funeral director
(b) Address 1000 Bradtley ave

19 (a) (Date rec'd by registrar) (b) Registrar

DEC 6 - 1945

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 28 1945 at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 25 1945 to Nov 28 1945 and that I last saw h living alive on Nov. 28 1945.

Immediate cause of death: Cerebral Hemorrhage — Duration: 4 days

Due to: Hypertension

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Thomas J. Stephens
Address Johns Hopkins Hosp. Date signed 11/28/45 M. D.

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34850 — BALTIMORE CITY HEALTH DEPARTMENT — G34850

CERTIFICATE OF DEATH 33a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun
(c) Hospital or institution: Franklin Square Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19h.
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1408 Webster St.
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME Jenkins, Albert (Albert E. Jenkins)

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: Wht.

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 1 1929

8. AGE: Years 16 | Months 11 | Days 4 | If less than one day - hr. - min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Stock Clerk

11. Industry or business

FATHER
12. Name William Jenkins
13. Birthplace Maryland

MOTHER
14. Maiden Name Idd Jenkins
15. Birthplace Maryland

16 (a) Informant Wm. L. Jenkins
(b) Address 1408 Webster St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-8-1945 (month), (day), (year)
(c) Cemetery or crematory Cedar Hill
Location A. A. Co. Md.

18 (a) Funeral director Flynn & Fleming
(b) Address 1416 Light St.

19 (a) (b)
(Signature of city registrar)

DEC 6 - 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-5 — 1945, at 12:05 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1, 1945, to Dec. 5, 1945, and that I last saw him alive on Dec. 5, 1945.

Immediate cause of death: Influenzal Pneumonia.

	Duration
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. P. Friedman

Address 1319 Light St. Date signed 12/5/45

X

634851

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937 ✓

634851 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 153 Exeter St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 153 N. Exeter St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lottie Richardson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M.

5. Color or race Col

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Richard

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 27, 1888

8. AGE: Years 57 | Months 8 | Days 9 | If less than one day hr. min.

9. Birthplace Md (Town, county and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name George W Lyte
13. Birthplace Md

MOTHER
14. Maiden Name Jennie Carter
15. Birthplace Md

16 (a) Informant Daniel Richardson
(b) Address 253 N Exeter St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/10/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location B. A. County Md.

18 (a) Funeral director Joseph B. Lyle
(b) Address 1306 N. Eutaw St
(c) 12-7-1945 (Date received by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/6 1945 at 12:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6/8 1945 to 12/6 1945; and that I last saw h.x.t. alive on Dec. 6 1945.

	Duration
Immediate cause of death Congestive Pulmonary edema	
Due to Congestive heart failure	6 months
Due to Myocardial degeneration	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. E. Bunnell M. D.
Address 171 Argyle St Date signed 12/7/45

VS 150

G348552

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B ✓

Registered No. G348552

CMK-97652

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 59- 2- 16

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1128 East Lexington Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Robinson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 19-1886

8. AGE: Years	Months	Days	If less than one day
59	2	16	hr. min.

9. Birthplace Baltimore-Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Phil Robinson
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth Ward
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof 12/10/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location

18 (a) Funeral director Joseph B. Locke Jr
(b) Address 1364 N. Central Ave

DEC 7 - 1945 Huntington Williams M.D.
(Date rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 5 1945, at 6:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 5 1945 to Dec. 5 1945, and that I last saw h. im alive on Dec. 5 1945.

Immediate cause of death	Duration
Pulmonary Tuberculosis	2
Hemorrhage	
Due to	
Due to	
Other Conditions Asteptic sclerosis, generalized (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy: Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert B. Copeland Jr M.D.
Address Balt. City Hosp. Date signed 12/6/45

~~34853~~ BALTIMORE CITY HEALTH DEPARTMENT ✓ 63485-3

CERTIFICATE OF DEATH 47D

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp. 9-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
4 City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2430 Mathew St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Aram John Carpenter

3 (b) If veteran, name war W

3 (c) Social Security Account No. None

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Estelle Carpenter

6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) May 20 1898

8. AGE: Years (48) 47 | Months 6 | Days 11 | If less than one day ..... hr. ..... min.

9. Birthplace Armenia (Town, county, and state)

10. Usual Occupation Life Insurance

11. Industry or business Fidelity Life Ins. Co.

FATHER 12. Name John Carpenter

13. Birthplace Armenia

MOTHER 14. Maiden Name Lucille Mardirosian

15. Birthplace Armenia

16 (a) Informant Mrs. Aram J. Carpenter

(b) Address 2430 Mathew St.

17 (a) Burial (Burial, cremation, removal) (b) Date thereof 12/8/45 (month) (day) (year)

(c) Cemetery Moreland Park

Location Parkville, Md.

18 (a) Funeral director William Cook Inc.

(b) Address 127 St. Paul St.

(c) Date received by Registrar DEC 7 - 1945 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec - 6 - 1945, at 1:10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov - 25 - 1945, to Dec - 6 - 1945, and that I last saw him alive on Dec - 6 - 1945.

Immediate cause of death	Duration
1898 Respiratory Collapse	
Due to Carcinoma of Lung	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George H. Fahrenkamp M.D.

Address Date signed 12/6/45

X

G34854

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G34854 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1807 Rutland Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1807 Rutland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Francis M. Merriken

3 (b) If veteran, name war No
3 (c) Social Security Account No. No

4. Sex M | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. W.

6 (b) Name of husband or wife Katie E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 8th 1864

8. AGE: Years 81 | Months 0 | Days 28. | If less than one day hr. min.

9. Birthplace Balto Md. (Town, county, and state)

10. Usual Occupation Machinist - Retired

11. Industry or business

FATHER
12. Name Francis M. Merriken
13. Birthplace Balto

MOTHER
14. Maiden Name Wahnsan
15. Birthplace "

16 (a) Informant Robert B. Merriken
(b) Address 1807 Rutland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/10/45 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave.

18 (a) Funeral director W. C. Cole Inc.
(b) Address 1217 St Paul St

19 DEC 7 - 1945 (Registered number) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 6 1945 at 10 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 10 1945 to Dec 6 1945; and that I last saw him alive on Dec 6, 1945.

Immediate cause of death	Duration
Myocarditis	4 yrs
Due to Arterio Sclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Grant Taylor M. D.
Address 1823 N. Rutland Ave. Date signed 12/6/45

VS 150

X

G34855

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

6

G34855
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Druid and Bayard 16
(c) Hospital or institution: West Baltimore General Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2004 Rayner Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Betty Cox

3 (b) If veteran, name war	3 (c) Social Security Account No.
W	NONE

4. Sex	5. Color or race	6 (a) Single, ~~married, widowed, or divorced~~.
F	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 17th 1941

8. AGE: Years	Months	Days	If less than one day
4	3	18	hr. min.

9. Birthplace Baltimore Maryland.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Barney Cox
13. Birthplace Georgia

MOTHER
14. Maiden Name Dorothy Painter
15. Birthplace Balto. Md.

16 (a) Informant Dorothy Cox
(b) Address 2004 Rayner Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/8/45 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Balto. Md.
Location

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

DEC 7 - 1945 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-5 1945 at 6:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-5-45 1945, to 12-5 1945, and that I last saw h alive on 12-5-45 at 5 P.M.

Immediate cause of death	Duration
Cerebral Thrombosis	
Due to Hemiplegia [illegible]	over
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Benedict Baldeman M.D.
Address West Baltimore General Hosp. Date signed 12-5-45

Benedict Baldeman M. D. X

G34856

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G34856

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1700 N Caroline Street
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Harford
(c) City or town Belair
(If outside city or town limits, write RURAL and give town)
(d) Street No. 204 Bond st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary W Dailey

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: None

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: William R. Dailey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec about 1898

8. AGE: Years 47 | Months 2 | Days 2 | If less than one day: hr. min.

9. Birthplace Cambridge, Md.
(Town, county, and state)

10. Usual Occupation Housework
11. Industry or business At Home

FATHER
12. Name Joshua B. Brown
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah Harrison
15. Birthplace Md.

16 (a) Informant William R. Dailey Jr.
(b) Address 204 Bond St. Belair Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 10-45
(month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cemetery
Location Eastern Ave Extended

18 (a) Funeral director William Booth Inc
(b) Address 1217 Ost Paul St

DEC 7 – 1945 (Date rec'd by Registrar) Washington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-6 1945, at 5 15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-29 1945 to 12-6 1945, and that I last saw her alive on 12-6 1945.

Immediate cause of death: Massive Cerebral Hemorrhage. — Duration:
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation: Cerebral Hematoma.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:
23. Signature Eugene J Riley
Address 1400 N Caroline Date signed 12-6-45

Eugene J. Riley M.D.

VS 150

G348-57

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 180

G348-57 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert + Saratoga Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 d.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 805 Eutaw St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Worsham

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Agnes Worsham
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 21, 1907

8. AGE: Years	Months	Days	If less than one day
38	7	14	hr. min.

9. Birthplace North Carolina
(Town, county, and state)
10. Usual Occupation Truck driver
11. Industry or business

FATHER
12. Name Arthur Worsham
13. Birthplace North Carolina

MOTHER
14. Maiden Name Mary Williams
15. Birthplace North Carolina

16 (a) Informant Agnes E. Worsham
(b) Address 1034 Greenmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-7-45 (month) (day) (year)
(c) Cemetery or crematory Westwood
Location Baltimore

18 (a) Funeral director Frederick A. Dole
(b) Address 1740 W. Lombard St

DEC 7 - 1945 (Date rec'd by registrar)
(b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/5 1945, at 2:?? M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/3 1945, to 12/5 1945, and that I last saw h[illegible] alive on 12/5 1945.

Immediate cause of death Cardiac Resp. Failure

Due to Shock

Due to Exposure

Other Conditions Burns 3° face + hands
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 12-3-45 at A. M
(c) Where did injury occur? E. 1 Eutaw St
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? no
(Specify type of place)
(e) Means of injury Fire from oil stove explosion

23. Signature W. K. Brindle M. D.
Address Mercy Hosp. Date signed 12/5/45

VS 150 To be completed and approved by Medical Examiner's Office

G34858 | BALTIMORE CITY HEALTH DEPARTMENT | G34858

CERTIFICATE OF DEATH

Registered No. 170c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Sparrows Point
(If outside city or town limits, write RURAL and give town)
(d) Street No. 612 J Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Morris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: M.

6 (b) Name of husband or wife: Willie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years: 49 | Months | Days | If less than one day: hr. min.

9. Birthplace Goochland Co. Va.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace " "

MOTHER
14. Maiden Name Emma Morris
15. Birthplace Va.

16 (a) Informant Willie Morris
(b) Address 816 E. Lexington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-9-45 (month) (day) (year)
(c) Cemetery or crematory Edgewood
Location Goochland Co. Va.

18 (a) Funeral director Saml. W. Stone & Son
(b) Address 638 E. Belvedere

19 (a) DEC 7 - 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 6, 1945, at 5:45 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:
(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH: Compound fracture of left leg.

Osteomyelitis, left leg.

Acute bacterial endocarditis.

Other Conditions: Bilateral bronchial pneumonia.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-27-45 at 10:30 P. M.
(b) Where did injury occur? 1800 block McCulloh St. 30 ft. N. of Lanvale
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No.
(d) Means of injury: Pedestrian struck by truck.

23. Signature Benedict Skaitakis M.D.
Medical Examiner.
Date signed December 6, 1945

14/3

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634859

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

634859 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Providence Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) Died
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1911 Brunt St
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Emma Knox

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Widowed

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — — 1880

8. AGE: Years	Months	Days	If less than one day
65	—	—	..... hr. ..... min.

9. Birthplace Maryland (town, county, and state)
10. Usual Occupation House work
11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Mrs Hassaway
(b) Address 1911 Brunt St

17 (a) Burial (b) Date thereof 12 8 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cem
Location Baltimore Md

18 (a) Funeral director Robert E. Jennings
(b) Address 1501 Madison ave

19 (a) (Date rec'd) DEC 7 1945 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/6 1945, at 1:25 P.M.

21. I certify that I took charge of the remains described above, held an Inspection-Inquest and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to hcm death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

Autopsy, Inspection or Inquiry

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature P. V. Dalkowski M.D.
Medical Examiner.
Date signed 12/6/45

US 51

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

479737. 634880

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92a

Registered No. 634880

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 7/12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4212 Wickford Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Kirkland Lo Fry.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Alice R. Fry.
6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) 7-29-73.

8. AGE: Years 72 | Months 4 | Days 6 | If less than one day ... hr. ... min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Banker

11. Industry or business

FATHER
12. Name John E Fry
13. Birthplace Md.

MOTHER
14. Maiden Name Helen M. Hellen
15. Birthplace Md.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 7 '45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md.

18 (a) Funeral director John C. Mitchell & Sons
(b) Address 1900 Eutaw Place

19 DEC 7 1945 Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 5 1945 at 9.32 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 3 1945 to Dec. 5 1945 and that I last saw him alive on Dec. 5 1945.

Immediate cause of death	Duration
Heart Failure	3 mo
Due to { Cardiac Hypertrophy / Aortic Stenosis	? 2 yrs
Due to Rheumatic Heart Disease	49 yrs
Other Conditions Tbc. inactive pleural effusion (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Laurence Dickason M.D. M. D.
Address Johns Hopkins Hosp Date signed 12/8/45

G34861

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

G34861 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Ga. (b) County
(c) City or town Atlanta (If outside city or town limits, write RURAL and give town)
(d) Street No. 290 Argonne Drive N. W. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Roy S. Minnier

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Lillie Minnier
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-9-83.

8. AGE: Years	Months	Days	If less than one day
61	11	27	hr. min.

9. Birthplace N. Y. (Town, county, and state)
10. Usual Occupation Life Insurance Co.
11. Industry or business

FATHER
12. Name Frank Minnier
13. Birthplace Canada

MOTHER
14. Maiden Name Emily Fitch
15. Birthplace Canada

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 7/45 (month) (day) (year)
(c) Cemetery or crematory Montgomery
Location Balto.

18 (a) Funeral director John O. Mitchell Sons
(b) Address 1706 Eutaw Place

19 (a) (Date received by registrar) DEC 7 1945 (b) Huntington Williams (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-6 1945; at 8 15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-24 1945 to 12-6 1945, and that I last saw him alive on 12-6 1945.

Immediate cause of death [redacted]
General cachexia
Due to metastatic carcinoma
Due to primary carcinoma of bile duct
Other Conditions Bilat. nephrolithiasis
(Include pregnancy within 3 months of death)
Date of operation March 21. 1945
Major findings of operations: Carcinomatosis
of autopsy:

Duration
1½ yr.
?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M. D.
Address Johns Hopkin Hosp. Date signed 12-6-45

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34852

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G34852 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3441 Ash Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13-8
(e) Length of stay in Baltimore (yrs., mos., or days) 30 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3441 Ash Street (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Mildred Frances Parks

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Mar.

6 (b) Name of husband or wife John T. Parks

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 5-1863

8. AGE: Years 82 | Months 8 | Days — | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER 12. Name Layton Disk

13. Birthplace Virginia

MOTHER 14. Maiden Name Sarah Hurt

15. Birthplace Virginia

16 (a) Informant Harry A. Parks

(b) Address 3441 Ash Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 8-1945 (month) (day) (year)

(c) Cemetery or crematory St. Marys (Hampden)

Location Baltimore, Maryland

18 (a) Funeral director Burgee's Funeral Home

(b) Address 3631 Falls Road

19 (a) (Date rec'd by registrar) (b) Registrar

DEC 7 - 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 5 1945 at 9.55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 30 1945 to Dec 5 1945 and that I last saw her alive on Dec 5 1945.

	Duration
Immediate cause of death Myocardial Insufficiency	3 days
Due to Carcinoma Colon	2 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Arthur J. Davies M. D.

Address 800 W 34 St Date signed 12-6-45

X

634863

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 148a

Registered No. 634863

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Prov. Lewer Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dok
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1547 Woodyear St
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Katherine Austin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C.	

6 (b) Name of husband or wife.....

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1909

8. AGE: Years	Months	Days	If less than one day
36			.....hr. .....min.

9. Birthplace.....
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace unknown

MOTHER
14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant Rev. A W. Taylor
(b) Address 1025-N-Fulton Ave

17 (a) Burial (b) Date thereof 12/7/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Md. Calvary
Location A A. Co. Md.

18 (a) Funeral director Chas. H. Alexander
(b) Address 947 N. Mount St

DEC 7 - 1945
(a) Date rec'd by registrar
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/4 1945, at 7:00 M

21. I certify that I took charge of the remains described above, held an Inspection-Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carcinoma of Cervix

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury.....at.....M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?.....While at work?.....
(d) Means of injury.....

23. Signature [illegible]
Medical Examiner M.D.
Date signed 12/5/45

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34864 — 484553

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH ✓ 56 E

G34864 — Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Washington S.E. 20.6
(If outside city or town limits, write RURAL and give town)
(d) Street No. 9011 Old Fort Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: James Spivey
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	married

6 (b) Name of husband or wife: Pauline
6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) 11-17-00

8. AGE: Years	Months	Days	If less than one day
45	-	18	hr. min.

9. Birthplace: N.C.
(Town, county, and state)
10. Usual Occupation: Truck Driver
11. Industry or business

FATHER
12. Name: Joseph Spivey
13. Birthplace: N.C.

MOTHER
14. Maiden Name: Martha Balthrop
15. Birthplace: N.C.

16 (a) Informant: Records
(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Dec. 7 1945 (month) (day) (year)
(c) Cemetery or crematory
Location: Washington, D.C.

18 (a) Funeral director: J. B. Johnson
(b) Address: Annapolis

19 (a) (Signature of registrar) (b) DEC 7 - 1945 (Date received by registrar)

VS 150

Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 5 1945, at 11.15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 30 1945, to Dec. 5 1945, and that I last saw him alive on Dec. 5 1945

Immediate cause of death	Duration
Peripheral Circulatory Collapse	24 hrs
Due to Malignant Tumor	3 months
Due to	
Other Conditions	over

(Include pregnancy within 3 months of death)

Date of operation 12/4/45
Major findings of operation: Large Inoperable hypophyseal tumor
of autopsy: Not Done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: James E. Cowan III M. D.
Address: Johns Hopkins Hospital Date signed 12/6/45

COUSAR X

634865

CWK-97644

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

133a

634865

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Avenue

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 Hrs

(e) Length of stay in Baltimore (yrs., mos., or days) 66- 9- 28

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 2104 Boone Street
(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Mary Behrens

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Charles (D)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 6-1879

8. AGE: Years	Months	Days	If less than one day
66	9	28	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name John Smith

13. Birthplace Germany

MOTHER

14. Maiden Name Meinenhalder

15. Birthplace Germany

16 (a) Informant Records-Balto. City Hospitals

(b) Address 4940 Eastern Avenue

17 (a) Cremate (b) Date thereof 12-7-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Oak Lawn

Location 7225 Eastern ave

18 (a) Funeral director Calarena & Hoffmann

(b) Address 1639 n Broadway

19 (a) (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

DEC 7 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH December 4 1945, at 9:05 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 2 1945, to Dec. 4 1945, and that I last saw h.er alive on Dec. 4 1945.

Immediate cause of death Uremia — Duration ?

Due to Bilateral Hydro-Nephrosis — ?

Due to — ?

Other Conditions Recto-vesical cutaneous fistula — ?
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature E J Berry M.D.

Address BCH Date signed 12/4/45
M. D.

X

634866

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170 B

Registered No. 634866

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Any false information should be carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-2-A Ward.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town Nanticoke (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jacob Czyzycki

3 (b) If veteran, name war: N
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 1913

8. AGE: Years	Months	Days	If less than one day
32	4		hr. min.

9. Birthplace Nanticoke Pa (Town, county, and state)
10. Usual Occupation Shell Filler
11. Industry or business Bethlehem Steel Co

FATHER
12. Name Casimir Czyzycki
13. Birthplace Poland

MOTHER
14. Maiden Name Sophia Uracz
15. Birthplace Poland

16 (a) Informant Sophie Evans
(b) Address Nanticoke Pa

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 12/7/45 (month) (day) (year)
(c) Cemetery or crematory Nanticoke
Location Nanticoke Pa

18 (a) Funeral director Tillson & Doe
(b) Address 12 N St Paul St.

19 (a) DEC 7 1945 Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 5, 1945, at 9 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fractured Skull (vault and base)
Fractures of all four bones on left side, fractured collar bone.

Other Conditions Multiple bruises brush burns and lacerations.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-5-45 at 9:30 P. M.
(b) Where did injury occur? Hanover St. 900' south Reed Bird Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Auto. side swiped auto and then into pole

23. Signature Howard J. Medeiros M.D.
Medical Examiner.
Date signed 12-6-45

VS 151

634867

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

634867 Registered No. 1648

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Any information not available on certificate should be supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hosp 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dec 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1816 Bolton Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nana M Leyton

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 220-07-1337

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Divorced

6 (b) Name of husband or wife SIMEON

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 27 1905

8. AGE: Years	Months	Days	If less than one day
39	11	8 10	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Asst Buyer

11. Industry or business Hutzler Bros.

FATHER
12. Name George Ludwig
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Mandie Culbertson
15. Birthplace Falls Md.

16 (a) Informant Mrs Nana M Creden
(b) Address 1816 Bolton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-8-45 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director Fulton Funeral Home
(b) Address 1 E Saint St

DEC 7 - 1945

19 (a) (Date rec'd by registrar) (b) Huntington Whitehouse, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 6 1945, at 7:30 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 20/6

(a) Date of injury 12-5-45 at 6 P. ? M.
(b) Where did injury occur Underbridge - Hilkins Avenue + Gwynns Falls Parkway.
(c) Did injury occur at home, on farm, industrial place, in public place? Public. While at work? No.
(d) Means of injury Found drowned.

23. Signature Benedict Skiotarelis M.D.
Medical Examiner.
Date signed 12-6-45

G34858

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

G34858 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Also correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4601 Pall Mall Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1823 E. Balto. St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME David Shiffern

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Sarah

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 18 –

8. AGE: Years	Months	Days	If less than one day
63			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Wife
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-7-45 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Phil Rd + Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Balto. St

19 (a) (b) Huntington Williams
(Date rec'd by registrar)

VS 150 DEC 7 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 5th 1945 at 11 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 16 1942 to Dec. 5th 1945 and that I last saw h— alive on 12/5 1945

Immediate cause of death	Duration
Bronchial asthma, arterio-sclerotic heart disease	1943
Due to General arterio sclerosis	
Due to Coronary thrombosis	1945
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. G. Nicholson M. D.
Address 2230 Eutaw Pl. Date signed 12/6/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be sure to correct age is especially important.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

634879 √61

Registered No. 634879

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2910 REIST. RD
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 + 5
(e) Length of stay in Baltimore (yrs., mos., or days) 48 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO (If outside city or town limits, write RURAL and give town)
(d) Street No. 2910 REIST. RD (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME IDA EPSTEIN

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: FEMALE
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: WIDOW
6 (b) Name of husband or wife: LOUIS
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1872
8. AGE: Years 73 | Months | Days | If less than one day hr. min.
9. Birthplace RUSSIA (Town, county, and state)
10. Usual Occupation NONE
11. Industry or business

FATHER
12. Name NOT KNOWN
13. Birthplace RUSSIA

MOTHER
14. Maiden Name NOT KNOWN
15. Birthplace RUSSIA

16 (a) Informant ALVIN EPSTEIN
(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12-9-45 (month) (day) (year)
(c) Cemetery or crematory BNAI ISRAEL
Location SOUTHERN AVE

18 (a) Funeral director JACK LEWIS INC
(b) Address 1439 E. BALTO. ST.

19 (a) (Date rec'd by registrar) DEC 7 - 1945 (b) Registrar Huntington Hollins, Jr.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/6/45 19 , at M

21. I certify that death occurred on the date above stated, that I attended deceased from 11/18 19 to 12/6/45 19 , and that I last saw h alive on 12/6/45 19 .

Immediate cause of death	Duration
Coronary thrombosis	2 hrs
Due to	
Due to Hypertension	?
Other Conditions Diabetes mellitus	?

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature
Address 2904 Reist Rd Date signed 12/6/45

VS 150

-9da

G3487.0

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G3487.0
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1418 N. Central Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto c
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1418 N. Central Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Susie Bedford

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C.

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Elijah

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/1/89

8. AGE: Years 56 | Months 11 | Days 2 | If less than one day hr. min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Jones
13. Birthplace Md

MOTHER
14. Maiden Name Martha ?
15. Birthplace Md

16 (a) Informant Katherine Walker
(b) Address 1418 N. Central Ave

17 (a) Burial (b) Date thereof 12/7/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location B. C. County Md

18 (a) Funeral director Joseph B. Loehr
(b) Address 1300 N. Central Ave

19 DEC 7 1945 (b) Huntington Williams, M.D.
(Date received by Local Registrar) (Signature of Local Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/3 1945 at 4:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-4-1944, to 12-3-1945, and that I last saw h.e alive on 12-2-1945.

Immediate cause of death Cardiac Arrest

Due to —

Due to

Other Conditions Hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 1922 E. Chase Date signed 12-7-45

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634871 BALTIMORE CITY HEALTH DEPARTMENT 634871

CERTIFICATE OF DEATH 307

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 32 South Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 521 N. Fremont Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Barnes

3 (b) If veteran, name war | 3 (c) Social Security Account No.

Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	married

6 (b) Name of husband or wife Julia Barnes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1895 —

8. AGE: Years	Months	Days	If less than one day
60			hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER 12. Name Edward Barnes
13. Birthplace St. Mary Co. Md.

MOTHER 14. Maiden Name Bell Briscoe
15. Birthplace St Mary Co. Md.

16 (a) Informant Julia Barnes
(b) Address 521 N. Fremont Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 7 '45. (month) (day) (year)
(c) Cemetery or crematory Western Star
Location Catonsville, Md.

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St. Baltimore, Md.

1945 DEC 7 (Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 4, 1945, at 11 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Rupture of Aortic Aneurysm into the Esophagus

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skotarchic M.D. Medical Examiner.
Date signed December 4, 1945.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34872 (State File No.)

BALTIMORE CITY HEALTH DEPARTMENT ✓ G34872 Registered No.

CERTIFICATE OF DEATH 131a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 60 Yrs. ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 691 Pierce Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Florence West

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife John West
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ??? 1885

8. AGE: Years	Months	Days	If less than one day
60	?	?	hr. min.

9. Birthplace Baltimore-Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof Dec. 8-'45.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St.

DEC 7 1945 (b) Huntingtor Williams, M.D.
(Date rec'd by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 4 1945, at 3:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1-1945, to Dec. 4 1945, and that I last saw her alive on Dec. 4 1945.

Immediate cause of death	Duration
Shock	?
Due to Uremia	?
Due to Arteriosclerosis	?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Arteriosclerosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Marguerite M. Davis M. D.
Address 4940 Eastern Ave. Date signed 12-4-45

X

G34873

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH / 318

G34873 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4700 Harford Rd.
(c) Hospital or institution:
Snyder's Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3312 N. Calvert St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLA ANNA CROCKETT

3 (b) If veteran, name war –

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Charles B. Crockett
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 6, 1871

8. AGE: Years	Months	Days	If less than one day
74	1	29	hr. min.

9. Birthplace Wicomico Co., Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name William Harrington
13. Birthplace Dorchester Co., Md.

MOTHER
14. Maiden Name Anna Messick
15. Birthplace Md.

16 (a) Informant Mr. C. Clyde Crockett
(b) Address Cooper Apts., 2 Maryland Ave. Annapolis, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/8/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

DEC 7 - 1945 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 5, 1945, at 1:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 9 1945 to Dec 5 1945; and that I last saw her alive on Dec 5 1945.

Immediate cause of death
Chronic Parenchymatous Nephritis

Duration
3 Yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None

of autopsy: Not

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Not
(b) Date of occurrence at M
(c) Where did injury occur? None
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? None While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 5106 Harford Rd Date signed 12/6/45

G34874

CWK-97046

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G34874
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0- 1- 4-
(e) Length of stay in Baltimore (yrs., mos., or days) 44 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2705 Miles Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Bierley

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife: George Bierley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 23-1861

8. AGE: Years	Months	Days	If less than one day
84	9	12	hr. min.

9. Birthplace Pennsylvania
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Samuel Peacock
13. Birthplace Pa.

MOTHER
14. Maiden Name Hester Ann Eyer
15. Birthplace Pa.

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/8/45 (month) (day) (year)
(c) Cemetery or crematory St. Mary's Cem.
Location Hampden, Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

DEC 7 - 1945
(Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 5 1945, at 8:05 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1 1945, to Dec. 5 1945, and that I last saw h.. alive on Dec. 5 1945.

Immediate cause of death	Duration
Cardiac failure	
Due to arteriosclerotic heart disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: none
of autopsy: Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature T. P. Jernigan
Address Baltimore City Hosp. Date signed 12-5-45 M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34875

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G34875 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6019 Bellona Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life - 58 4 4

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6019 Bellona Ave.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Talbot Edel McAfee

3 (b) If veteran, name war: First World
3 (c) Social Security Account No. 215-07-0493

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Ida May McAfee
6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) July 27, 1887

8. AGE: Years	Months	Days	If less than one day
58	4	8 10	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business Glenn L. Martin Co.

FATHER
12. Name Clarence McAfee
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Sara Edel
15. Birthplace Baltimore, Md

16 (a) Informant Wife
(b) Address 6019 Bellona Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 8 1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Wm J. Tickner & Sons
(b) Address North & Penna. Aves.

DEC 7 - 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 6 1945, at 7.45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 22 1945, to Dec. 4 1945, and that I last saw him alive on Dec. 4 1945.

Immediate cause of death: Coronary Thrombosis — Duration ?
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W E Cole M. D.
Address 6014 York Road Date signed 12-6-45

634876

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 634876

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) DOA

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1410 North Broadway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LIDA PACKARD

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Roscoe M. Packard

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 23, 1869

8. AGE: Years 76 | Months 6 | Days 13 | If less than one day hr. min.

9. Birthplace Bath
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Hill
13. Birthplace Salisbury

MOTHER
14. Maiden Name Priscilla Handiboe
15. Birthplace Port de Paix Dem. Dept.

16 (a) Informant
(b) Address 1410 N. Broadway

17 (a) Burial (b) Date thereof Dec 8 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location Balto. Md.

18 (a) Funeral director Agnes Fritz
(b) Address 203 N. Broadway

19 (a) DEC 7 - 1945
(Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/5/45 19..., at 3:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Weis, M.D.
Medical Examiner.
Date signed 12/6/45

VS 151

G34877

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G34877 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 15

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1352 N. Calhoun St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jamie Pratt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	Black	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-12-42

8. AGE: Years	Months	Days	If less than one day
3	6	24	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Child
11. Industry or business

FATHER
12. Name James Edward Riggs
13. Birthplace Md.

MOTHER
14. Maiden Name Mamie Pratt
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/9/45 (month) (day) (year)
(c) Cemetery or crematory Sylvan Lawn Cemetery
Location Silver Spring, Md.

18 (a) Funeral director Geo. L. Wilson
(b) Address 1303 Presstman St.

DEC 7 - 1945 (Date rec'd by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec - 5 1945, at 7.55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec - 5 1945 to Dec - 5 1945, and that I last saw him alive on Dec - 5 1945

Immediate cause of death: Heart Failure — Duration 12 hr.
Due to: Pneumonia & Empyema of
Due to: undetermined Cause
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. H. Williams M.D.
Address H.H. Date signed 12-6-45

over

G34878

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

Registered No. G34878

Type or print plainly in black ink. Physicians: please write the causes of death clearly and legibly. Give correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 931 Linden Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 931 Linden ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ~~Elizabeth (Nunnally Lewis)~~ Lewis Nunnally

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	Married

6 (b) Name of husband or wife Freddie Nunnally

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 1923

8. AGE: Years	Months	Days	If less than one day
22	1		hr. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name George Lewis
13. Birthplace North Carolina

MOTHER 14. Maiden Name Gladys Manns
15. Birthplace North Carolina

16 (a) Informant George Lewis
(b) Address 931 Linden Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-9-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Adolphus Halsted
(b) Address 918 Druid Hill Ave

19 (a) 7 — 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-5- 1945, at 9 A M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH acute Lymphatic Leukemia.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madden M.D. Medical Examiner.
Date signed 12-6-45

VS 151

63487 9

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

Registered No. 63487 9

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 114 S. Wolfe St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 32

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 114 South Wolfe
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME AGATHA GINSICI

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife John

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb. 2, 1856

8. AGE: Years 89 | Months 10 | Days 3 | If less than one day ... hr. ... min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name — Lublewskai
13. Birthplace Poland

MOTHER
14. Maiden Name Unknown
15. Birthplace Poland

16 (a) Informant Mr. John Ginskai
(b) Address 114 S. Wolfe Street

17 (a) Burial (b) Date thereof 12/10/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Rd. Samuel Roys

18 (a) Funeral director M. J. Sadowski & Sons
(b) Address 1808 Eastern Ave

19 (a) (Date rec'd by Registrar) (b) Timothy Tom Williams, M.D. Registrar

DEC 7 1945

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/5/45 19..., at 5 P.M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Devin M.D.
Medical Examiner.
Date signed 12/6/45

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Use only black ink. Do not use pencil. Use no abbreviations except customary ones.

G34880

SEATO

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G34850 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: 713 S. Wolfe Street
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 713 S. Wolfe St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Seato

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years 70 | Months | Days | If less than one day hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business —

FATHER
12. Name
13. Birthplace Poland

MOTHER
14. Maiden Name —
15. Birthplace Poland

16 (a) Informant Andrew A. Seato
(b) Address 2503 Brit Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-10-45 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart of Mary
Location Balto Co.

18 (a) Funeral director Wm. J. Fialkowski
(b) Address 2007 Eastern Ave

19 (a) DEC 7 - 1945 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH December 1945, at 8:15 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Norris M.D.
Medical Examiner.
Date signed 12-6-45

VS 151

correct age is especially important. Physicians: please write the c

G34881

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G34881

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33RD & Calvert Sts.
(c) Hospital or institution:
Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 95 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. ALTAMONT Hotel, Eutaw & LANVALE.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME [redacted] BREVITT (Katherine MacKenzie)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
FEMALE	White	Widowed

6 (b) Name of husband or wife MR. EDWARD J BREVITT
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY 17, 1850

8. AGE: Years	Months	Days	If less than one day
95	6	21 20	hr. min.

9. Birthplace BALTIMORE, Md.
(Town, county, and state)
10. Usual Occupation NONE
11. Industry or business

FATHER
12. Name THOMAS MACKENZIE
13. Birthplace MARYLAND

MOTHER
14. Maiden Name ELENORA ISABELLA BREVITT.
15. Birthplace MARYLAND

16 (a) Informant MRS. John M. MacKENZIE
(b) Address 104 W. University Pkwy City.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-8-45 (month) (day) (year)
(c) Cemetery or crematory Friends'
Location Baltimore

18 (a) Funeral director Sullivan Myers Co.
(b) Address 1818 Monument.

19 DEC 7 - 1945 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 6 1945, at 9 10 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 28, 1945, to Dec 6, 1945, and that I last saw HER alive on Dec 6, 1945.

Immediate cause of death	Duration
Bronchopneumonia, Left.	
Due to	
Due to	
Other Conditions Arteriosclerotic Cardio-Vascular disease, (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature J. Frank Supplee, III
Address Union Memorial Hosp. Date signed 12/6/45 M. D.

107

G34882 ✓ G34882

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 126B

Registered No.

Every item of information should be carefully supplied. Write plainly, with UNFADING INK. Every correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene St.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ days
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1439 Reynolds Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Chester Krzykowski KRZYKOWSKI

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Bertha Krzykowski
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1893

8. AGE: Years	Months	Days	If less than one day
52			hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Poland

MOTHER
14. Maiden Name Unknown
15. Birthplace Poland

16 (a) Informant Bertha Krzykowski
(b) Address 1439 Reynolds Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 10 45 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary (Cem.
Location Baltimore County

18 (a) Funeral director John M. Weber
(b) Address 401 S. Chester Street

DEC 7 - 1945 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 5, 1945 19 45, at 6:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 3 19 45, to Dec 5 19 45, and that I last saw him alive on Dec 5 19 45.

Immediate cause of death Respiratory failure — Duration Chronic for several yrs.
Due to Uremia
Due to Kidney damage (Toxic)
Other Conditions Toxic Nephritis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William H. Robinson
Address University Hosp Date signed 12/5/45 M. D.

132

634883

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170B

Registered No. 634883

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto. General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-0 A
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County A. A County
(c) City or town Brooklyn Park
(If outside city or town limits, write RURAL and give town)
(d) Street No. 907 Victory Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nolan Mc Elwee

3 (b) If veteran, name war	3 (c) Social Security Account No.
235-18-8931	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Hazel
6 (c) If alive, give age 21 years

7. Birth date of deceased (mo., day, yr.) Oct 4 1944

8. AGE: Years	Months	Days	If less than one day
31	2	1	hr. min.

9. Birthplace West Virginia
(Town, county, and state)
10. Usual Occupation Chipper In
11. Industry or business Shipyard

FATHER
12. Name Maverlet Mc Elwee
13. Birthplace W. Virginia

MOTHER
14. Maiden Name Jane Bly
15. Birthplace W. Virginia

16 (a) Informant Hazel Mc Elwee
(b) Address 907 Victory Ave -

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/8/45 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Baltimore Highways

18 (a) Funeral director Martin J. Conroy Jr.
(b) Address 4800. Baltimore Highways.

19 (a) Date received by Local Registrar DEC 7 1945 (b) Signature of Registrar Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 5, 1945, at 9 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH
Fractured skull (vault and base)

Due to

Other Conditions Fract. 3rd & 4th ribs, mult. lacerations abrasions, & BBs. Fract. left femur
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-5-45 8:30 P.M.
(b) Where did injury occur? Hanover St. 100' South of 3rd St. Public Road
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Struck by side swiped streetcar

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 12-6-45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

369327 634884 BALTIMORE CITY HEALTH DEPARTMENT X ✓ 634884 Registered No.

CERTIFICATE OF DEATH 30c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State D.C. (b) County
(c) City or town Washington (If outside city or town limits, write RURAL and give town)
(d) Street No. 1841 Columbia Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Arthur J Day

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	married

6 (b) Name of husband or wife Ethel Day
6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) 2-10-85

8. AGE: Years	Months	Days	If less than one day
60	9	27	hr. min.

9. Birthplace Penn. (Town, county, and state)
10. Usual Occupation Public Relation
11. Industry or business

FATHER
12. Name William R. Day
13. Birthplace Penn.

MOTHER
14. Maiden Name Rachel Davenport
15. Birthplace Penn.

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 10 45 (month) (day) (year)
(c) Cemetery or crematory Ft Lincoln Cemetery
Location Road D.C.

18 (a) Funeral director Martin W. Thyson Co
(b) Address 1330 N. Ld. N.H. Road D.C.

19 (a) Huntington Williams M.D. Registrar
(Date rec'd by registrar) 12-1945 VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 7- 1945 at 4 50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-25-1945 to 12-7-1945 and that I last saw him alive on 12-7-1945

Immediate cause of death	Duration
Cardiac Failure	2 days
Due to Hypertensive Cardio-Vascular Disease	? 10 yrs
Due to ? Intracranial Hemorrhage	
Other Conditions CNS syphilis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Laurie Dickson M.D.
Address Johns Hopkins Hosp Date signed 12/7/45

937

G34885

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G34885

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 219 S. High St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 47 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 219 S. High St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maria Rizzo

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband ~~xxxxxx~~ late Gennaro Rizzo

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 22 1876

8. AGE: Years	Months	Days	If less than one day
69	9	13	hr. min.

9. Birthplace Acropoli Italy
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business home

FATHER
12. Name Luigi Landolfi
13. Birthplace Italy

MOTHER
14. Maiden Name Giuseppina Aieto
15. Birthplace Italy

16 (a) Informant Frances Montone (Daughter)
(b) Address 4807 Homer Ave

17 (a) Burial (b) Date thereof Dec. 10 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Della Rocca
(b) Address 52 W. Monroe St.

19 (a) 1945 (b) Pennington Williams, M.D.
(Entered by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 5th 1945 at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 4 1945, to — 19—, and that I last saw h.e alive on Dec 4th 1945

Immediate cause of death	Duration
Pulmonary Edema	20 hours
Due to Cardio Vascular disease	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature H. J. Lautin M. D.
Address 100 N. Mullen Date signed 12/6/45

VS 150 For C. J. R. Davis, by Howard J. Lautin, M.D. X

G34886 BALTIMORE CITY HEALTH DEPARTMENT G34886
CERTIFICATE OF DEATH 61 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline + Oliver Sts.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Days.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto. City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5109 Harford Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country 5109 Harford Rd.

3 (a) FULL NAME Mr. William Repsher. Repsher

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M/2 | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/8/78

8. AGE: Years 67 | Months 7 | Days 28 | If less than one day hr. min.

9. Birthplace Pa. (Town, county, and state)

10. Usual Occupation Baker

11. Industry or business

FATHER 12. Name George Repsher
13. Birthplace

MOTHER 14. Maiden Name Sarah Florey
15. Birthplace

16 (a) Informant Mr. J. Fred Rueckert
(b) Address 5019 Harford Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-8-45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Rd.

19 (a) 12-7-1945 (Date received by registrar) (b) Hunter Foster Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/6 1945 at 11:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/4 1945 to 12/6 1945 and that I last saw him alive on 12/6 1945.

Immediate cause of death Cardio-Respiratory Failure

Due to Cerebrovascular Stroke

Due to Thrombosis

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John T. Everett M. D.
Address Bon Secours Hospital Date signed 12/6/45

VS 150

104 B

Dr. Campbell
1644 Hanover 634887

BALTIMORE CITY HEALTH DEPARTMENT ✓634887
CERTIFICATE OF DEATH 61 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2715 Latona Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore -14-
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2715 Latona Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Florence E. Taylor

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Isaiah Taylor
6 (c) If alive, give age 88 years

7. Birth date of deceased (mo., day, yr.) Sept. 7, 1868

8. AGE: Years	Months	Days	If less than one day
77	3	--	hr. min.

9. Birthplace England (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name ? Dalton
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mr. Isaiah Taylor
(b) Address 2715 Latona Road -14-

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/10/45 (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road-14-

19 (a) Filed by registrar Huntington Williams, M.D. Registrar
12-7-1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 7, 1945 at 9a M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1945 to 12/7 1945 and that I last saw h[illegible] alive on 12/6 1945

Immediate cause of death Acute Dilatation of Heart — Duration 2 days
Due to Diabetes Mellitus — Indefinite
Due to — Indefinite
Other Conditions Cerebral Hemorrhage
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. L. Campbell M.D.
Address 1644 Hanover Date signed 12/7/45

X

G34888 BALTIMORE CITY HEALTH DEPARTMENT G34888

CERTIFICATE OF DEATH

97 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Give the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address U
(c) Hospital or institution:
Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 18 hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town West Annapolis
(If outside city or town limits, write RURAL and give town)
(d) Street No. 713 Gittings Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Erna Currier

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Wh.	Married

6 (b) Name of husband or wife Albert E. Currier
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 14-1911

8. AGE: Years	Months	Days	If less than one day
34	8	23	hr. min.

9. Birthplace Munich - Germany
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Otto Seidberger
13. Birthplace Germany

MOTHER
14. Maiden Name ? ?
15. Birthplace Germany

16 (a) Informant Albert E Currier
(b) Address 713 Gittings Ave - West Annapolis

17 (a) Burial (b) Date thereof 12/10/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Annapolis Md
Location

18 (a) Funeral director E. W. Lamoreaux
(b) Address 4510 Liberty Heights Ave.

19 (a) DEC 8 1945 (b)
(registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec - 7 - 1945, at 11 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec-6-1945 to Dec-7 1945, and that I last saw h.er alive on Dec-7-1945

Immediate cause of death: Pulmonary Congestion — Duration

Due to Hemolytic Nonsyph Congestion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George F. Schlesinger M. D.

Address Date signed 12/7/45

Huntington Williams, M.D.

634889

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

44B

634889 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: U.S. Marine Hospital, Balto, Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 days
(e) Length of stay in Baltimore (yrs., mos., or days) 24 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Fla. (b) County
(c) City or town Bunnell (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Jones, Francis Semmes

3 (b) If veteran, name war

3 (c) Social Security Account No. 265-05-3191

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Aline Jones
6 (c) If alive, give age 31 years

7. Birth date of deceased (mo., day, yr.) Aug. 27, 1912

8. AGE: Years	Months	Days	If less than one day
33	3	10	..... hr. ..... min.

9. Birthplace Tampa, Florida (Town, county, and state)
10. Usual Occupation Chief cook
11. Industry or business Seafaring

FATHER
12. Name Hafford Jones
13. Birthplace Tenn.

MOTHER
14. Maiden Name Jane ?
15. Birthplace Ala.

16 (a) Informant Records
(b) Address US Marine Hospital, Balto, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 11-45 (month) (day) (year)
(c) Cemetery or crematory Myrtle Hill
Location Tampa, Fla.
18 (a) Funeral director Old Funeral Home Inc.
(b) Address 4644 York Road
19 (a) ..... (b) Huntington Williams M.E. (Date rec'd by registrar) Registrar

DEC 8 - 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 6 1945, at 7:54P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 12 1945 to Dec. 6 1945, and that I last saw him alive on Dec. 6 1945.

Immediate cause of death	Duration
Hodgkin's disease	
retroperitoneal nodes, liver	
and spleen	UNKNOWN
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John A. Wilson
John A. Wilson, Sr. Surgeon M.D.
Address Clinical Director Date signed 12/7/45
US Marine Hospital, Balto, Md.

X

634890

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

178 C

Registered No. 634890

correct age is especially important. Physicians: please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1217 North Eden Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Percie Leroy Heath

3 (b) If married, name wife

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Minnie Heath

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 20-1923

8. AGE: Years	Months	Days	If less than one day
22	8	15	hr. min.

9. Birthplace Camden S.C. (Town, county, and state)

10. Usual Occupation Barber

11. Industry or business

FATHER 12. Name Leroy Heath
13. Birthplace S.C.

MOTHER 14. Maiden Name Maude Heath
15. Birthplace S.C.

16 (a) Informant Mrs Minnie Heath
(b) Address 1217 N. Eden st.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 12/8/45 (month) (day) (year)
(c) Cemetery or crematory
Location Chester, S. C.

18 (a) Funeral director Joseph E. Locke Jr.
(b) Address 1304 N. Central Ave

DEC 8 - 1945 (Date received by Registrar) (b) Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 4, 1945, at 1 30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation due to Carbon monoxide

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Dec. 3rd-4th 1945 ? M.
(b) Where did injury occur? 1217 North Eden ST
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Faulty Furnace Flue

23. Signature Robert Lee Grattan M.D. Medical Examiner.
Date signed Dec. 4 1945

114

634891

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

634891 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully written. Be sure the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2592 W. Fayette st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2592 W. Fayette st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ella Woolfenden

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) ~~Single, married~~, widowed, or divorced: Widowed

6 (b) Name of husband ~~or wife~~: Frank Woolfenden

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 3rd 1855

8. AGE: Years 90 | Months 3 | Days 4 | If less than one day hr. min.

9. Birthplace Howard Co. Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business At Home

FATHER
12. Name Lot Nicholson
13. Birthplace Howard Co. Md.

MOTHER
14. Maiden Name Louise Johnson
15. Birthplace Howard Co. Md.

16 (a) Informant Mrs Karl Kaufman
(b) Address 2592 W. Fayette St.

17 (a) Burial (b) Date thereof 12/11/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul st

19 (a) Dec 10 1945 (Date received by Registrar) Wm. Williamson M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 7th 1945, at 9a. M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/5 1945 to 12/7 1945, and that I last saw h. alive on 12/7 1945

Immediate cause of death: Fractured at hips — Duration 4 wks

Due to: Fall

Due to:

Other Conditions: Bronchopneumonia — 1 day
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 20/2
(a) Accident, suicide, or homicide accident
(b) Date of occurrence 12/4/45 at 10 a. M
(c) Where did injury occur? Balto Md
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? no
(Specify type of place)
(e) Means of injury Fall down stairs

23. Signature Benjamin Miller M.D.
Address 2130 Walker Date signed 12/12/45

For S. C. J. Zubinski, by Howard D. Mason, Jr. M.D.

G34892

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

171a

G34892 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3 E. 33rd St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Herman D Hinternesch (HINTERNESCH)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of ~~husband or~~ wife Catherine M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 22nd 1863

8. AGE: Years 82 | Months 7 | Days 15 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Lawyer

FATHER
12. Name Dietrick Hinternesch
13. Birthplace Germany

MOTHER
14. Maiden Name Uekerem
15. Birthplace "

16 (a) Informant Catherine M. Hinternesch
(b) Address 3 E. 33rd St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/10/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Lorraine
Location Balto. Co. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) (Date rec'd by Registrar) (b) Huntington Williams, M.D.

DEC 8 1945

V-151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-7- 1945, at M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, ~~accident~~ ☒ suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured Skull

Due to

Other Conditions Cerebral Hemorrhage, Diabetes, Arteriosclerosis, Chronic Nephritis
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☒ cause of death, fill in the following:
(a) Date of injury 12-1-45 at 4.40 A.M.
(b) Where did injury occur? St Paul & 33rd Sts
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Walked into moving street car.

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed 12-7-45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. 634893

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ..... St Joseph Hosp
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4712 Simmons Ave (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Stanley Tomaszewski

3 (b) If veteran, name war	3 (c) Social Security Account No.
W	----

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife ..... Mary
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 6 1879

8. AGE: Years	Months	Days	If less than one day
66	6		hr. ..... min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business

FATHER	12. Name Unknown
	13. Birthplace Poland
MOTHER	14. Maiden Name Unknown
	15. Birthplace Poland

16 (a) Informant Stanley Tomaszewski
(b) Address 1969 Eutaw Pl. Baltimore

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/11/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md

18 (a) Funeral director Wilhelm Corp Inc
(b) Address 1214 Eager St Baltimore, Md

19 (Date received by registrar) DEC 8 1945 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-7 1945; at 11:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-18 1945 to 12-7 1945, and that I last saw h[illegible] alive on 12-7 1945.

Immediate cause of death	Duration
Respiratory failure	
Due to Acute cardiac failure	
Due to Myocarditis & Pneumonia	
Other Conditions Cerebrovascular accident	

(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: .....
of autopsy: .....

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... (Specify type of place) While at work? .....
(e) Means of injury .....

23. Signature Wm H. Frank. M. D.
Address c/o H. Jos. Hays. Date signed 12-7-45

VS 150

G34894

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 1210

G34894
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 68 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State S.C. (b) County
(c) City or town Walterboro (If outside city or town limits, write RURAL and give town)
(d) Street No. 19 Sanders St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) **FULL NAME** Laura Turner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	Negro	widow

6 (b) Name of husband or wife Herman Turner

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 15, 1892

8. AGE: Years	Months	Days	If less than one day
53	-	22	hr. min.

9. Birthplace Walterboro S.C. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Harvey Grant.
13. Birthplace S.C.

MOTHER
14. Maiden Name Nancy ——
15. Birthplace S.C.

16 (a) Informant Bradford Turner (Son)
(b) Address 1313 Oakland Ave - Balto. Md.

17 (a) Interment (Burial, cremation, or removal) (b) Date thereof Dec. 9 1945 (month) (day) (year)
(c) Cemetery or crematory
Location Walterboro S.C.

18 (a) Funeral director Joseph H. Cooper
(b) Address 804 W. Carlisle St

19 (a) DEC 8 - 1945 (Date filed by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-7 1945; at 4:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-1 1945, to 12-7 1945, and that I last saw h.er alive on 12-7 1945.

Immediate cause of death Cerebral hemorrhage — Duration 2-3 years

Due to Hypertensive Cardio-vascular Renal disease — Duration 15 yrs

Due to — Duration

Other Conditions Cerebral degeneration — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Myrtle J. Woodland M.D.
Address 861 Hanlon A Date signed 12/7/45

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34895

BALTIMORE CITY HEALTH DEPARTMENT X G34895
CERTIFICATE OF DEATH V 13 a
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 46 days
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Granite
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) **FULL NAME** Lillian Duvall

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	Negro	divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1890 (?)

8. AGE: Years	Months	Days	If less than one day
55			hr. min.

9. Birthplace Montgomery Cty Md.
(Town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER 12. Name Charles Duvall
13. Birthplace Md.

MOTHER 14. Maiden Name Carrie Johnson
15. Birthplace Md.

16 (a) Informant Luther Duvall
(b) Address Granite, Md.

17 (a) Burial (b) Date thereof 12-10-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St Alphonsus
Location Granite, Md.

18 (a) Funeral director F. C. Duckenhorn
(b) Address Ellicott City Md.

19 DEC 8 1945 (b) Huntington Williams, M.D.
(Date received by Registrar) (Signature of Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-7 1945, at 5:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-23 1945 to 12-7 1945, and that I last saw her alive on 12-7 1945.

Immediate cause of death Cerebral hemorrhage — Duration

Due to Hypertensive cardiovascular-renal disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles J. Wardlaw M.D.
Address 861 Hanlon Date signed 12-9-45

G34896

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92a

G34896 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 918 Little Pine Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 918 Little Pine St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elisabeth Davis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Married

6 (b) Name of husband or wife Frank Davis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1891

8. AGE: Years	Months	Days	If less than one day
54			hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Henry West
13. Birthplace Md.

MOTHER
14. Maiden Name Laura Carroll
15. Birthplace Md.

16 (a) Informant Mr. Francis Davis
(b) Address 1018 Shields Place

17 (a) Burial (b) Date thereof 12-11-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 528 W. Biddle St.

19 (a) 12-8-1945 (b) Huntington Williams M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 7, 1945 19 , at 5P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-16 1945 to 12/7 1945
and that I last saw [illegible] alive on 12/6 1945

Immediate cause of death Aortic Regurgitation — Duration 3 Mo

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature B. N. Hale M. D.
Address 1 W Pen Ave Date signed 12/7/45

G34897

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 145 B

Registered No. G34897

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 822 N. Carrollton Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 822 N. Carrollton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: EDWARD BOWEN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1867

8. AGE: Years	Months	Days	If less than one day
78			hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Janitor
11. Industry or business

FATHER
12. Name Joseph Bowen
13. Birthplace Md.

MOTHER
14. Maiden Name Anna ?
15. Birthplace Md.

16 (a) Informant N.M. Carroll Home for Aged
(b) Address 822 N. Carrollton Ave.

17 (a) Burial (b) Date thereof 12-10-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 Dec 9 1945 Huntington Williams M.D.
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 6, '45 19 at 5P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 10 19 45 to Dec. 6 19 45 and that I last saw h cr alive on Dec. 6 19 45

Immediate cause of death Carcinoma of Tongue — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. W. Deckelmann Jr. M.D.
Address 4 N. Johnson Date signed 12/8/45

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

~~34898~~ 634898

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 83a

Registered No. 634898

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 642 W. Franklin St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 642 W. Franklin St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME NETTIE HARGES

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 1,1870

8. AGE: Years	Months	Days	If less than one day
75	10	5	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William Ebb
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah Howard
15. Birthplace Md.

16 (a) Informant Mr. Walter S. Ebb
(b) Address 345 Robert St.

17 (a) Burial (b) Date thereof 12-10-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemaley
(b) Address 578 W. Biddle St.

(a) DEC 8 - 1945 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION A

20. DATE OF DEATH Dec. 6, '45 19 , at 11:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-29-45 19 , to 12-6-45 19 , and that I last saw h[illegible] alive on 12-6-45

Immediate cause of death: Tuberculosis Pulmonary — Duration 5 yrs.
Due to: Hardening
Due to: Pulmonary Tuberculosis
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Lee Ellis M. D.
Address 9 E. Madison St. Date signed 12-7-45

VS 150

634899

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

634899 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully written. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 117 So Schroeder St
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 9
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 117 So Schroeder St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles F. J. Carroll

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) April 9th 1882

8. AGE: Years	Months	Days	If less than one day
63	7	28	hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)
10. Usual Occupation Chief Dep. Clerk
11. Industry or business City Court house

FATHER
12. Name John F. Carroll
13. Birthplace Ireland

MOTHER
14. Maiden Name Catherine Kelly
15. Birthplace Ireland

16 (a) Informant Mrs. Mary A Carroll
(b) Address 117 So. Schroeder St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/10/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Road

18 (a) Funeral director John Lowen & Son
(b) Address 901-03 Hollins St

19 (a) (Date rec'd by registrar) (b)

vs no. DEC 8 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 7th 1945, at 5:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1944 to Dec 7. 1945.
and that I last saw him alive on 12/7 1945.

Immediate cause of death Repeated myocardial degeneration — Duration 1 year
Due to Arteriosclerosis
Due to
Other Conditions Arteriosclerosis with hypertension — 5 yrs.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D. F. Alagia M. D.
Address 53 Hebbard Bldg Date signed 12/7/45

Huntington Hollins

G34500

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. G34500

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore - S - Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2417 Rolland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Quirino (Harry) D'Adamio

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-07-1362

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	

6 (b) Name of husband or wife Assunta (nee Cieri)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 26, 1888

8. AGE: Years	Months	Days	If less than one day
57	8	10	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business Consolidated Tailoring Co.

FATHER
12. Name Serafine D'Adamio
13. Birthplace Italy

MOTHER
14. Maiden Name Unknown
15. Birthplace Italy

16 (a) Informant Mrs. Helen B. Cassady-daughter
(b) Address 816 N. Milton Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/10/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street
(c) (Date rec'd by registrar) DEC 8 - 1945 (d) Signature for Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 6 1945 at 7:30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/26/1945 to 12/6/1945, and that I last saw him alive on 12/6/1945.

Immediate cause of death	Duration
Peripheral Circulatory Collapse	3 hrs.
Due to Gast. Ca. Ramatang Stomach.	
Due to	
Other Conditions C.A. Sylvis Stomach	

(Include pregnancy within 3 months of death)
Date of operation Dec 4/45
Major findings of operation: C.A. Stomach
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thos Morton Jr M.D.
Address Bon Secours Hosp. Date signed 12/6/45

X

G34901

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 12 1a

Registered No. G34901

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given correctly and legibly. Physicians: please write the causes of death clearly and be especially important. Correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2724 Tivoly Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-6
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2724 Tivoly (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country —

3 (a) FULL NAME Joseph Sippel

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Anna L. Sippel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 8th 1876

8. AGE: Years	Months	Days	If less than one day
69	5	29	hr. min.

9. Birthplace Balto. Co. Md (Town, county, and state)

10. Usual Occupation Gas & Electric Co.

11. Industry or business

FATHER
12. Name John Sippel
13. Birthplace

MOTHER
14. Maiden Name Susan Friskey
15. Birthplace

16 (a) Informant Mrs. Joseph Sippel
(b) Address 2724 Tivoly Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 10 45 (month) (day) (year)
(c) Cemetery or crematory Jerusalem Luth
Location Balto Md.

18 (a) Funeral director Lasahn Funeral Home
(b) Address 7401 Belair Rd.

DEC 8 - 1945 (Date rec'd by registrar) (a) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 7th 1945, at 7 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-15-1944 to 12-7-1945, and that I last saw h alive on 12-7-1945.

Immediate cause of death	Duration
Arteriosclerotic cardio-renal failure	Uncertain
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. B. Sybert, M.D.

Address 1801 Harford Rd Date signed 12-8-45

VS 150

634902

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 27

634902 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully obtained and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5214 Alhambra Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5214 Alhambra Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Catherine McNulty

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife John McNulty
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 27, 1886

8. AGE: Years	Months	Days	If less than one day
58	11	10	hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Patrick McDonald
13. Birthplace Ireland

MOTHER
14. Maiden Name Sarah Welsh
15. Birthplace Ireland

16 (a) Informant John McNulty
(b) Address 5214 Alhambra Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/10/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Maryland

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) (b)

Date rec'd by local registrar DEC 8 - 1945 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 7 1945, at 7 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 6 1945 to Dec. 7 1945, and that I last saw h.er alive on Dec. 6 1945.

	Duration
Immediate cause of death: Acute Dilatation Heart	6 hrs.
Due to Endocarditis Myocarditis	5 yrs.
Due to Arteriosclerosis	5 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Earl H. Benson, M.D.
Address 511 York Rd Date signed 12/7/45 M. D.

X

HARRIS

G34903

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183a

Registered No. G34903

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correct age is especially important. Physicians: please write the causes of death clearly and legibly. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1932 Madison Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 - 3

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1932 Madison Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Callie L Harris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Howard Harris

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 22nd 1900

8. AGE: Years 43 | Months 2 | Days 14 | If less than one day hr. min.

9. Birthplace Crumdel Co Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Richardson Hilton

13. Birthplace Crumdel Co Md

MOTHER 14. Maiden Name Mary Catherine

15. Birthplace Crumdel Co Md

16 (a) Informant Colwell Proctor

(b) Address 1932 Madison Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof 12-16-45 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Cemetery

Location Balto Md.

18 (a) Funeral director Archibald J Gaddis

(b) Address 2101 N. Caroline St.

19 (a) (Date rec'd by Local Reg.) (b)

DEC 8 - 1945

Remington Williams Miller

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/6 1945 at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/24 1945 to 12/6 1945 and that I last saw her alive on 12/6 1945

Immediate cause of death	Duration
Cerebral Apoplexy	
Due to Paralysis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Burkett M. D.

Address 2 My Dr Date signed 12/6 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given if obtainable. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634904

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

634904 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4013 Liberty Hgts
(c) Hospital or institution:
Alberta Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 5/10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town 3814 Sequoia Ave. (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANK JOSEPH ERNST

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Emma Keck Ernst
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 14, 1871

8. AGE: Years	Months	Days	If less than one day
74	1	22	hr. min.

9. Birthplace Punxsutawney, Pa. (Town, county, and state)
10. Usual Occupation Dentist - Retired
11. Industry or business

FATHER
12. Name Henry Ernst
13. Birthplace Germany

MOTHER
14. Maiden Name Katherine Spiess
15. Birthplace Germany

16 (a) Informant Mrs. Katherine Jones
(b) Address 4016 Kathland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/8/45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) DEC 8 1945 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 6, 1945, at 2:30PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4/11 1941 to 12/6 1941 and that I last saw him alive on 12/6 1941.

Immediate cause of death: Carcinoma of Pancreas & metastases — Duration 5 mo.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert A. Rettie M. D.
Address 3408 Windsor Ave. Date signed 12/7/45

VS 150

G34905

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 54a

Registered No. G34905

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be sure correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton + Hilkens Ave
(c) Hospital or institution:
St. Agnes Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 1/2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Odenton
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Bryce J. Shoemaker

3 (b) If veteran, name war: none

3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Margaret H.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 23, 1903

8. AGE: Years 42 | Months 4 | Days 14 | If less than one day ..... hr. ..... min.

9. Birthplace S. Carolina (Spartanburg)
(Town, county, and state)

10. Usual Occupation Elec. Estimator

11. Industry or business

FATHER
12. Name Hess J. Shoemaker
13. Birthplace S. Carolina

MOTHER
14. Maiden Name Mary Louise Bryce
15. Birthplace S. Carolina

16 (a) Informant Mrs. Margaret H. Shoemaker
(b) Address Odenton, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/10/45 (month) (day) (year)
(c) Cemetery or crematory Episcopal Cem.
Location Odenton, Md.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address Balto., Md.

DEC 8 1945 (Date received by Registrar) (b) Thurlington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/7 1945 at 7:35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/2 1945, to 12/7 1945, and that I last saw h alive on 12/7 1945

Immediate cause of death	Duration
Infiltrating Adenocarcinoma of left cerebral hemisphere	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 12/4/45 - 12/6/45

Major findings of operation: Infiltrating Adenocarcinoma of left hemisphere

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jose A Alvarez de Chardon

Address St Agnes Hosp Date signed M. 12 D. 7/45

VS 150

#34906

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

Registered No. 34906

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount
(c) Hospital or institution:
Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 days
(e) Length of stay in Baltimore (yrs., mos., or days) 27 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Talbot
(c) City or town Easton
(If outside city or town limits, write RURAL and give town)
(d) Street No. None : Route #4 Box #4
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** ELLA SCHWANINGER

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	~~M~~ W

6 (b) Name of husband or wife Charles Schwaninger
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 19, 1880

8. AGE: Years	Months	Days	If less than one day
65	2	20	hr. min.

9. Birthplace Easton, Talbot, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Joseph Longnecker
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Mary Young
15. Birthplace Maryland

16 (a) Informant Records of Hospital
(b) Address Broadway & Fairmount Ave

17 (a) Burial (b) Date thereof Dec 12/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Fairview Cemetery
Location Cordova, Maryland

18 (a) Funeral director Stewart & Brown Company
(b) Address 108 W. North Ave, City #1.

19 DEC 10 1945 Huntington Williams M.D.
(Date received) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/9 1945, at 5.20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/13 1945 to 12/9 1945 and that I last saw her alive on 12/9 1945.

Immediate cause of death Cardiac failure — Duration

Due to Carcinomatosis (Colon mid) 1 yr.

Due to Ovarian Adenoma

Other Conditions Hypertension Arteriosclerotic disease
(Include pregnancy within 3 months of death)

Date of operation 11/14/45

Major findings of operation: Peritoneal carcinomatosis

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ernest H. Farmer M. D.
Address Church Home & Hospital Date signed 12/11/45

VS 150

O.A. account No. 634907

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95B

Registered No. 634907

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 513 Quail St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eloise L. Long ELOIS L, LONG

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/22/1905

8. AGE: Years 20 | Months 8 | Days 14 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name John O Long
13. Birthplace Baltimore

MOTHER
14. Maiden Name Josephine Davies
15. Birthplace Baltimore Md

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/10/45 (month) (day) (year)
(c) Cemetery or crematory Moreland mem
Location Taylor ave

18 (a) Funeral director Clarence F Hoffman
(b) Address 1639 N Broadway

DEC 8 - 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-6 1945 at 5 16 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-6-1945 to 12-6-1945 and that I last saw him alive on 12-6-1945

Immediate cause of death Pulmonary embolism — Duration

Due to Cardiac enlargement + dilatation + arteriosclerosis + hypertension

Due to Rheumatic heart disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John A. Vane
Address Johns Hopkins Hosp. Date signed 12/6/45

VS 150 For J.C. Sherbak, by Howard J. Mueller, M.D.

634908

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

634908 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. Be sure correct age is especially important. Physicians: please write the causes of death clearly and legibly

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3306 Walbrook Ave.
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3306 Walbrook Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Emma A. Basye

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Frederick E. Basye
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 4, 1854

8. AGE: Years	Months	Days	If less than one day
91	6	3	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Reade W. Corry
(b) Address 104 Bloomsbury Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/8/45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn, Md.

18 (a) Funeral director John D. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 DEC 8 1945 [illegible] Wilmot M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH December 7 1945, at 4A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/4 1945 to 12/7 1945, and that I last saw h[illegible] alive on 12/6 1945.

Immediate cause of death	Duration
Coronary occlusion	3 days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 37 W. Preston St. Date signed

VS 150

G34500115

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G34509

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution:
JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1022 E. Biddle St (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME William Keene
3 (b) If veteran, name war —
3 (c) Social Security Account No. —
4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced. —
6 (b) Name of husband or wife —
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Nov. 20, 32
8. AGE: Years 13 Months Days 16 If less than one day .....hr. .....min.
9. Birthplace Md - (Town, county, and state)
10. Usual Occupation School -
11. Industry or business

FATHER
12. Name Leonard Keene
13. Birthplace Md -

MOTHER
14. Maiden Name Rose Gerlach -
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/10/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cemetery
Location Belair Rd.
18 (a) Funeral director M. A. E. Dypski Sons
(b) Address 600 E. Fayette St.
19 (a) Registered by (b) Huntington Williams, M.D. Registrar
DEC 8 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 6 1945 at 6 P. M
21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 30 1945 to Dec 6 1945 and that I last saw him alive on Dec 6 1945

Immediate cause of death	Duration
Hyperpyrexia	
Due to Cause undetermined	
Due to	
Other Conditions	prev.

(Include pregnancy within 3 months of death)
Date of operation 12/4/45
Major findings of operation: Hodgkin's disease Lymphosarcoma
of autopsy: Not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence.....at.....M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?.....While at work?.....
(Specify type of place)
(e) Means of injury.....
23. Signature Lawrence W. Smith, M.D.
Address Johns Hopkins Hospital Date signed 12/6/45

VS 150

634910

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

$3a

Registered No. 634910

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct. Age is especially important. Physicians: please write to the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5514 Wesley Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5514 Wesley Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE HENRY WAHMANN

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Lottie May Wahmann
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 27, 1876

8. AGE: Years	Months	Days	If less than one day
69	5	9	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Sheet Metal Mfg.
11. Industry or business Self

FATHER
12. Name Jurgen H. Wahmann
13. Birthplace Germany

MOTHER
14. Maiden Name Frances J. Ernst
15. Birthplace N. J.

16 (a) Informant: Mrs. Lottie M. Wahmann
(b) Address 5514 Wesley Ave.

17 (a) Burial (b) Date thereof 12/8/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Maryland

19 (a) Huntington Williams M.D.
(Date rec'd by registrar) (Registrar)

DEC 9 1945

MEDICAL CERTIFICATION A

20. DATE OF DEATH Dec. 6, 1945, at 11:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 1945 to Dec. 6 1945 and that I last saw him alive on Dec 5 1945.

Immediate cause of death Hypertensive Cerebral — Duration

Due to Not ascertained

Due to

Other Conditions Cerebral arteriosclerosis amounting to senility for [illegible]

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Mahlon Thomas M.D.
Address Med. Arts Bldg. Date signed 12/6/45

X

G34911

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170C

G34911 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1009 N. Wolfe St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Campbell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1913

8. AGE: Years 32 | Months | Days | If less than one day hr. min.

9. Birthplace SC
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name James Campbell
13. Birthplace SC

MOTHER
14. Maiden Name Ophelia Johnson
15. Birthplace SC

16 (a) Informant Ella Mae Campbell
(b) Address 608 W Conway St

17 (a) Removal (b) Date thereof 12/5/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Gastonia
Location North Carolina

18 (a) Funeral director Isaiah L Brown
(b) Address 108 W Montgomery St
(Undertaker or other person acting as such)

DEC 6 1945

Huntington Williams

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 5, 1945, at 8 A. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Rest death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Skull fracture
Epidural hematoma
Due to Diffuse subdural hemorrhage

Other Conditions Contusions of brain
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7:45 P.M. 12-4-45
(b) Where did injury occur? In vicinity of Lexington & Market
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? Yes
(d) Means of injury Fell from trash truck

23. Signature Benedict Skotarcke M.D.
Medical Examiner.
Date signed 12-5-45

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634912

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183

634912 Registered No.

1. PLACE OF DEATH: Found - Fleet St. & Fallsway.
(a) Baltimore City, Maryland
(b) Street address 700 Fleet Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 706 N. Eaton Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Tommy Cabrinas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 12, 1926

8. AGE: Years 19 | Months 10 | Days 21 | If less than one day hr. min. 18

9. Birthplace Danville Va (Town, county, and state)

10. Usual Occupation Packing House Helper

11. Industry or business

FATHER 12. Name James Cabrinas

13. Birthplace N. Y.

MOTHER 14. Maiden Name Sylvia Brown

15. Birthplace Va

16 (a) Informant Sylvia Cabrinas

(b) Address 706 N. Eden St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-8-45 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvery

Location

18 (a) Funeral director Elroy O. Wilson

(b) Address 1000 Pleasant Lane

DEC 8 - 1945 (Date rec'd by reg.) (b) Huntington Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 3 1945, at M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury Found 12-3-45 9:45 A. M.

(b) Where did injury occur Fleet St. + Fallsway

(c) Did injury occur at home, on farm, industrial place, in public place? Public. While at work?

(d) Means of injury Found Drowned.

23. Signature Benedict Skitarelic M.D.
Medical Examiner.

Date signed December 4, 1945

G34913 BALTIMORE CITY HEALTH DEPARTMENT G34913
CERTIFICATE OF DEATH 93D Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Fremont
(c) Hospital or institution:
Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town Westminster
(If outside city or town limits, write RURAL and give town)
(d) Street No. Washington Road.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Clara E. Howard

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex: F
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Edgar Howard
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 15-1873

8. AGE: Years 72 | Months 7 6 | Days 23 | If less than one day hr. min.

9. Birthplace Carroll Co.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER 12. Name Samuel Strickler
13. Birthplace Carroll Co
MOTHER 14. Maiden Name Mary Barnes
15. Birthplace Carroll Co

16 (a) Informant Edgar Howard
(b) Address Westminster, Md.

17 (a) Burial (b) Date thereof Dec. 11-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Pleasant
Location Carroll Co

18 (a) Funeral director H. Bankard, Inc
(b) Address Westminster, Md.

19 (a) DEC 9 1945 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 8 1945, at 10:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from December 5 1945 to Dec. 8 1945, and that I last saw h.. alive on Dec. 8 1945.

Immediate cause of death Cardiac failure — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. M. Caudill M. D.

Address Maryland General Hospital Date signed 12-8-45

G34914 BALTIMORE CITY HEALTH DEPARTMENT G34914
Registered No.

CERTIFICATE OF DEATH 186a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Linden ave Madison
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County Carroll
(c) City or town Westminster (If outside city or town limits, write RURAL and give town)
(d) Street No. 269 E. Main St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Elizabeth Haesenburg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
W/F	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/22/1862

8. AGE: Years	Months	Days	If less than one day
83	2	16	hr. min.

9. Birthplace md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Moses Shaffer
15. Birthplace

MOTHER 14. Maiden Name Elabeth Hildebrandle
15. Birthplace

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-10-45 (month) (day) (year)
(c) Cemetery or crematory Westminster
Location Westminster

18 (a) Funeral director J. H. Reese
(b) Address Westminster md

DEC 9 - 1945 (Date rec'd by Registrar)

(a) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-8 1945, at 3:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-3 1945 to 12-8 1945, and that I last saw her alive on 12-8 1945

Immediate cause of death: Arteriosclerotic Heart disease — Duration

Due to: HT

Due to:

Other Conditions: Fractured femur - left

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
*Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ~~12-8~~ Dec. 3, 1945
(c) Where did injury occur? Home of Westminster md
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? No
(Specify type of place)
(e) Means of injury Fall to floor

23. Signature

Address Md General Hospital Date signed 12/9/45
Howard J. Andrews M.D.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34915

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 D

Registered No. G34915

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
U.S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) 17 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Ga. (b) County
(c) City or town Augusta
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1325 Baker Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Speering, Frank Wade

3 (b) If veteran, name war	3 (c) Social Security Account No.
WW 2	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Dena May Speering
6 (c) If alive, give age 25 years

7. Birth date of deceased (mo., day, yr.) Apr. 7, 1922

8. AGE: Years	Months	Days	If less than one day
23	8	0	....hr. ....min.

9. Birthplace Augusta, Ga.
(Town, county, and state)
10. Usual Occupation --
11. Industry or business

FATHER
12. Name Fred Speering
13. Birthplace Augusta, Ga.

MOTHER
14. Maiden Name Nellie Mc Feely
15. Birthplace Augusta, Ga.

16 (a) Informant Records
(b) Address US Marine Hospital, Balto, Md.

17 (a) Burial (b) Date thereof Dec. 11-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Augusta Georgia

18 (a) Funeral director Dear Funeral Home Inc
(b) Address 4644 York Road

19 (a) 1945 Huntington Williams, Registrar
Date rec'd by registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 7 1945 at 1:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 20 1945 to Dec. 7 1945, and that I last saw him alive on Dec. 7 1945.

Immediate cause of death	Duration
Peritonitis, acute	1 wk
Due to Carcinoma of rectum	Unknown
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address Clinical Director Date signed 12/7/45
US Marine Hospital, Balto, Md.

634916

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. 634916

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: University Hospital 19

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5½ hrs.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 826 W. Lombard st.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) **FULL NAME** Clyde Koller (Claude S. Kohler)

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-03-0206

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife Georgia

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years	Months	Days	If less than one day
61			..... hr. ..... min.

9. Birthplace New Oxford Pa.
(Town, county, and state)

10. Usual Occupation Shoe, Cutter

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant L. Kohler Daughter
(b) Address

17 (a) Burial (b) Date thereof Dec. 9 '45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory New Oxford Pa.
Location New Oxford Pa.

18 (a) Funeral director Joseph Kasinskas
(b) Address 628 Washington Blvd

DEC 9 - 1945 (b) Washington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 7th 1945, at 9:15 M

21. I certify that I took charge of the remains described above, held an Insp. & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Lis. death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage, Spontaneous

Due to .....

Other Conditions ?

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at ..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 12-8-45

VS 151

Item or information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

G34917 BALTIMORE CITY HEALTH DEPARTMENT G34917

CERTIFICATE OF DEATH 937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1745 Ashland ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1745 Ashland ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jim (Wylie) Wiley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Married.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 4, 1898

8. AGE: Years 47 | Months - | Days 2 | If less than one day hr. min.

9. Birthplace Woodward S. C.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Sharp Wiley
13. Birthplace S. C.

MOTHER
14. Maiden Name Sarah Foster
15. Birthplace S. C.

16 (a) Informant Annie Wiley
(b) Address 1745 Ashland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-8-45 (month) (day) (year)

(c) Cemetery or crematory
Location Woodward, S. C.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brentwood ave

DEC 9 - 1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 6 1945, at 9:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 23 1945, to Dec 6 1945, and that I last saw him alive on Dec 5 1945.

Immediate cause of death: Cerebral Hemorrhage | Duration 6 days

Due to Hypertensive Cardio-Vascular Disease ?

Due to

Other Conditions Influenza | Nov 23.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. K. Carlson M.D.
Address 222 N. Caroline Date signed 12-7-45

G34918

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 33a

G34918 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2106 E. Hoffman St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ----
(e) Length of stay in Baltimore (yrs., mos., or days) About 84 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County --------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2106 E. Hoffman St.
(If rural give location)
(e) Citizen of foreign country? ------ (Yes or No)
If yes, name country ------

3 (a) FULL NAME Margaret Washington

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife --------
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) --------

8. AGE: Years	Months	Days	If less than one day
About 86	---	---	-- hr. --- min.

9. Birthplace England (Town, county, and state)
10. Usual Occupation None
11. Industry or business ------

FATHER
12. Name George Washington
13. Birthplace Liverpool, England

MOTHER
14. Maiden Name Margaret Claphan
15. Birthplace England

16 (a) Informant Mrs. Emma A. Washington
(b) Address 2106 E. Hoffman Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/10/45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director H. W. Meares & Son
(b) Address 805 N. Calvert Street

19 (a) DEC 9 1945 (Date received by Registrar) (b) Hunting for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 7, 1945 at 2 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1, 1945 to Dec. 7, 1945 and that I last saw her alive on Dec. 6, 1945.

	Duration
Immediate cause of death: Bronchopneumonia.	7 Days
Due to: Influenza	3 days
Due to: Arteriosclerosis	5 yrs
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Gilbert A. Fitzgerald, M.D.
Address 1613 E. North Ave. Date signed 12-8-45

VS 150

634919

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 634919 Registered No. 13B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 502 W Cross Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 502 W Cross Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Perry

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-07-4127

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/2/1904

8. AGE: Years	Months	Days	If less than one day
41		5	hr. min.

9. Birthplace Va (Town, county, and state)
10. Usual Occupation Saloon
11. Industry or business

FATHER
12. Name Walter Perry
13. Birthplace Va

MOTHER
14. Maiden Name Hattie Smith
15. Birthplace Va

16 (a) Informant Alice Longfield
(b) Address 502 W Cross Street

17 (a) Remains (Burial, cremation, or removal) (b) Date thereof 12/9/45 (month) (day) (year)
(c) Cemetery or crematory Franklin
Location Va

18 (a) Funeral director Sarah L Brown Son
(b) Address 108 W Montgomery Street

19 (a) (b) Registrar
(Date rec'd by registrar)
DEC 9 - 1945
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/7 194-, at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/2 194- to 12/7 194- and that I last saw h alive on 12/6 194-

Immediate cause of death Phlegmon Pulmonales — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 12/7 194-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct name is especially important. Physicians: please write the causes of death clearly and legibly.

634920 BALTIMORE CITY HEALTH DEPARTMENT 634920
CERTIFICATE OF DEATH 1945 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 724 Ensor St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 d
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 724 Ensor St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Gertrude Kenig

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Col	Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years	Months	Days	If less than one day
60			hr. min.

9. Birthplace Penna (Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name George Wooden
13. Birthplace Unknown

MOTHER
14. Maiden Name Annie Wooden
15. Birthplace Penna

16 (a) Informant Mary Jones
(b) Address 724 Ensor St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-9-45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. A. Co

18 (a) Funeral director Rayner Sanders
(b) Address DEC 9 1945 413 E. Preston St

19 (a) (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 6 1945, at 3 15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 25 1945 to Dec. 6th 1945 and that I last saw h[illegible] alive on Dec. 6 1945

Immediate cause of death Ulcerative Carcinoma Sigmoid

	Duration
Due to	
Due to	
Other Conditions Pneumonia (Influenza) (Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 1422 E. Chase Date signed 12-8-45

X

G34921

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G34921

Registered No. 46E

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) DOA

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 14 South Duncan (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Bennett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
m	col.	

6 (b) Name of husband or wife Bertha

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/15/1886

8. AGE: Years	Months	Days	If less than one day
59	5	20	hr. min.

9. Birthplace St Mary Co Maryland (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Joseph Bennett
13. Birthplace Md

MOTHER
14. Maiden Name Amanda Bennett
15. Birthplace Md

16 (a) Informant Bertha Bennett
(b) Address 14 S Duncan St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-10-45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location R. A. Co

18 (a) Funeral director Rayner Sanders
Address 1442 E Preston St

DEC 9 1945

19 (a) (Date rec'd by registrar) (b) Arlington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/5/45 19..., at 4:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions Surgical Colostomy due to Carcinoma Colon
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Sheri, Medical Examiner. M.D.

Date signed 12/6/45

G34922

HEALTH DEPARTMENT—CITY OF BALTIMORE

G34922

CERTIFICATE OF DEATH

✓4 13 L 3

Registered No.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 513 Westgate Road St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Maurice Bernard Sullivan If U. S. Veteran specify WAR WORLD WAR I

(a) Residence: No. 513 Westgate Road St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Anne G. McDevitt

6. DATE OF BIRTH (month, day, year) 2/27/1894

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
51	9	10	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Clerk Sup't

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Shell Oil Co

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Rockland Maine

FATHER

13. NAME James Sullivan

14. BIRTHPLACE (city or town) (State or country) Maine

MOTHER

15. MAIDEN NAME Mary Whalen

16. BIRTHPLACE (city or town) (State or country) Maine

17. INFORMANT Mrs Anne G. Sullivan

(Address) 513 Westgate Rd

18. BURIAL, CREMATION, OR REMOVAL

Place Boston Mass. Date 12 · 10 · 45

19. UNDERTAKER Harry H. Wetzke

(Address) 4101 Edmondson Ave

20. FILED 19

Registrar.

Funeral Director Williams, Md

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) 12 · 7 , 1945

22. I HEREBY CERTIFY, That I attended deceased from June 1, 1945, to December 7, 1945

I last saw him alive on Dec 7, 1945. Death is said to have occurred on the date stated above, at 11 45 a.m.

The principal cause of death and related causes of importance were as follows:

Cerebral Hemorrhage — Date of onset 12-7-45

Chronic Glomerular Nephritis

Hypertension

Other contributory causes of importance:

Was an operation performed? No Date of

For what disease or injury?

Name of operation

What test confirmed diagnosis? — Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury , 19

Where did injury occur?
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Vernon H. Norwood M. D.

(Address) 5101 Woodside Road

OCCUPATION is very important. See instructions on back of certificate.

V8 8

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634923

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

HB # 95596

1213

634923 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 16
(e) Length of stay in Baltimore (yrs., mos., or days) 25 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1426 W. Fayette St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Ralph McDaniel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Gladys Stoneburner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 23, 1899

8. AGE: Years	Months	Days	If less than one day
45	11	15	hr. min.

9. Birthplace Virginia
(Town, county, and state)
10. Usual Occupation Painter
11. Industry or business Self

FATHER
12. Name William McDaniel(d)
13. Birthplace Va.

MOTHER
14. Maiden Name Annie Stoneburner
15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals(Records)
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 12/11/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Mt Olivet
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

19 (a) 12-9-1945 Huntington Williams, M.D.
(Signature of registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 8, 1945, at 5:15A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 22, 1945, to Dec. 8, 1945 and that I last saw him alive on Dec. 8, 1945.

Immediate cause of death	Duration
Pulmonary Tuberculosis	?
Tuberculous Enteritis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: None
of autopsy: None a alone

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature T. P. Jernigan M. D.
Address Baltimore City Hos Date signed 12-8-45

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34924 — BALTIMORE CITY HEALTH DEPARTMENT — G34924 Registered No.

TN. 97423

CERTIFICATE OF DEATH 124a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2056 E. Hoffman St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank John Peters

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 13 1877

8. AGE:	Years	Months	Days	If less than one day
68	67	10	23	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Oven Man

11. Industry or business Rice Bakery

FATHER
12. Name John Peters
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Mary Paulus
15. Birthplace Baltimore Md.

16 (a) Informant Baltimore City Hospitals 4940 Eastern Ave (b) Records Elizabeth Lackner 2056 E. Hoffman St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/11/45 (month) (day) (year)

(c) Cemetery or crematory Moreland Park
Location Parkville Md

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

19 (a) DEC 9 1945 (Date received by registrar) (b) Huntington Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH December 6th 1945, at 6.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-21-45 19 , to 12-6-45 19 , and that I last saw him alive on 12-6-45 19 .

Immediate cause of death: Coronary Embolism — Duration: 9

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Margaret M. Davis M. D.
Address 4940 Eastern ave. Date signed 12-6-45

634925

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

634925 Registered No. 1637

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Md. General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) Died
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1637 Linden Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jewel Eheman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband ~~or wife~~: Geroge Eheman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 21 st 1907

8. AGE: Years: 38 | Months: 9 | Days: 17 | If less than one day: hr. min.

9. Birthplace: Ark. (Town, county, and state)

10. Usual Occupation: Clerk

11. Industry or business: Montgomery Wards

FATHER — 12. Name: Thomas E. Stidman
13. Birthplace: Ark

MOTHER — 14. Maiden Name: Nettie Young
15. Birthplace: Ark.

16 (a) Informant: George Eheman
(b) Address: 818 E. 35th St.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 12/12/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~: Loudon Park
Location: Balto. Md.

18 (a) Funeral director: William Cook Inc.
(b) Address: 1217 St. Paul St.

19 (a) DEC 9 - 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 8 - 1945 at 2 50 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to ~~his~~ her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Asphyxiation

Due to: Illuminating Gas

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-8-45 at 1 A. M.
(b) Where did injury occur? 1637 Linden Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no
(d) Means of injury: Asphyxiation, unlit, gas range.

23. Signature: Howard J. Mallett M.D. Medical Examiner
Date signed 12-8-45

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. WRITE PLAINLY, WITH UNFADING INK.

634926

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160a

634926

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkins + Caton Aves
(c) Hospital or institution:
St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2308 Mosher St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Townsman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 5, 1945

8. AGE: Years | Months | Days | If less than one day hr. 10 min.

9. Birthplace Baltimore 29, Maryland
(Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name [redacted] George J.
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Hiett
15. Birthplace Maryland

16 (a) Informant Mr George J Townsman
(b) Address 2308 Mosher St

17 (a) Burial (b) Date thereof 12-6-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director Lorenz Byers
(b) Address 5005 Park Heights Ave

19 (a) Dec 9 1945 (b) Huntington Williamsport Md
(Date received by registrar) Registrar's No.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/5 1945, at 12:55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/5 @ 12:55 45 to 12/5 @ 12:55 45.
and that I last saw her alive on 12/5 1945

Immediate cause of death (a) Intracranial Hemorrhage — Duration

Due to (b) Uterine Dystocia

Due to (c)

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [redacted] M.D. Elliott

Address St Agnes Hosp Date signed 12/6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634927

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

634927 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1000 Scott St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) Lifetime
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 616 Scott St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME KATIE REYNOLDS.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	Wht	Widow

6 (b) Name of husband or wife Dead.
(c) If alive, give age

7. Birth date of deceased (mo., day, yr.) June 14 1870

8. AGE: Years	Months	Days	If less than one day
75	5	27	hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation None.
11. Industry or business

FATHER 12. Name John Thomas Brooks
13. Birthplace Balto Md

MOTHER 14. Maiden Name Annie Walsh.
15. Birthplace Balto Md.

16 (a) Informant Marie Otter
(b) Address 616 Scott St

17 (a) Burial (b) Date thereof 12/11/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Edmondson Ave.

18 (a) Funeral director Geo. H. Leimbach
(b) Address 1358 N Fremont St.

19 (a) Huntington Williams, M.D.
(Date paid by registrar) Registrar

DEC 9 - 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/8 1945, at 7 a.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-10 1945, to 12/8 1945, and that I last saw h alive on 12/8 1945.

Immediate cause of death	Duration
Acute Cardiac Failure	1 da.
Due to Coronary Disease	6 mos.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph G Lawrence
Address 1796 Orkney Rd Date signed 12/8/45

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634928

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

634928
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Providence Hospital 1945
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1723 Cairo St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Beatrice Brown

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Separated

6 (b) Name of husband or wife Michael
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 6, 1896

8. AGE: Years	Months	Days	If less than one day
49	3	28	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Wm. Brown
13. Birthplace Md

MOTHER
14. Maiden Name Eliza Crowder
15. Birthplace Md

16 (a) Informant McKinley Brown
(b) Address 1204 W Franklin St.

17 (a) Burial (b) Date thereof 12/9/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 512 N. Carrollton Ave

19 (a) (b)
(Inserted by registrar) Registrar

EC 9-1945 VS-151 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/4 1945, at 3 P M

21. I certify that I took charge of the remains described above, held an Inspection-Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions Obesity

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 12/5/45

X

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

G34929

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G34929

Registered No.

PLEASE WRITE PLAINLY, with UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 11 Club Road
(c) Hospital or institution:
none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 11 Club Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jessie Merryman Myers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Eugene Rogers Myers
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 7, 1881

8. AGE: Years	Months	Days	If less than one day
64	8	1	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Franklin Merryman
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name ? France
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Bryson Christhilf
(b) Address Locust & Bellona Ave., Ruxton, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/10/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Govans Presbyterian Church
Location Baltimore, Md.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) 1945 (Date filed by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 8 1945, at 2:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 1930 to Dec 8 1945, and that I last saw her alive on Dec 8 1945

Immediate cause of death	Duration
Myocarditis	Several
Hypertension	
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature H H Moody
Address 1403 Park Ave. Date signed 12/9/45

VS 150

634930

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

634930 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours 27
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County --
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. LochRaven Blvd. (Pentridge Apts. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Louis A. Mueller

3 (b) If veteran, name war: no
3 (c) Social Security Account No. 219-07-2255

4. Sex: Male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Charlotte Mueller
6 (c) If alive, give age 59 years
7. Birth date of deceased (mo., day, yr.) Sept. 11, 1873

8. AGE: Years	Months	Days	If less than one day
72	2	25	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Real Estate
11. Industry or business

FATHER
12. Name Matthew C. Mueller
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Ann Keidel
15. Birthplace Germany

16 (a) Informant Mrs. Charlotte K. Mueller
(b) Address Pentridge Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/10/45 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director Chas. J. Evans & Son Inc.
(b) Address 118 N. Pth. Royal Ave
DEC 9 1945 (Date received by registrar) (By) Hunting for Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/6/45 1945 at 11:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/5 1945 to 12/6 1945 and that I last saw h[illegible] alive on 12/6 1945

Immediate cause of death: Acute Coronary Occlusion — Duration: 18 hrs.
Due to Coronary Thrombosis — 18 hrs.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature F. E. Strebel Jr M. D.
Address Bon Secours Hosp. Date signed 12/6/45

VS 150

G34931

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G34931 Registered No. 170

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2015 W. Fayette St.
(c) Hospital or institution:
Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 40 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5408 Springlake Way
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Edward Norris

3 (b) If ever in U.S. Army, Navy, or Marine Corps, name war
Yes 1 - Yes

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APR-30-1895

8. AGE: Years	Months	Days	If less than one day
50	7	7	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Physician

11. Industry or business

FATHER
12. Name Patrick N. Norris
13. Birthplace Ellicott. Md.

MOTHER
14. Maiden Name Cath. M. Manning
15. Birthplace Ireland.

16 (a) Informant Mrs Cath. Norris
(b) Address 5408 Springlake Way

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/10/45 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Old Frederick Road

18 (a) Funeral director J. J. Fahey Sons
(b) Address 1210 Light St.

19 (a) 1945 (Filled by registrar) (b) Countersigned by Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-7- 1945 at 4 20 AM

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushed Chest

Due to

Other Conditions Acute Pulmonary Edema

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 12/1
(a) Date of injury 12-5- at 8.30 a. M.
(b) Where did injury occur? 39th St. & St. Paul St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? Yes
(d) Means of injury Automobile: struck by truck

23. Signature Thomas J. Mullen M.D.
Medical Examiner.
Date signed 12-7-45

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34932

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

G34932 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (~~yrs., mos.,~~ or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Brooklyn
(If outside city or town limits, write RURAL and give town)
(d) Street No. 800 Engine Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Edith Bittinger

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept 22nd 1930

8. AGE: Years 15 | Months 2 | Days 17 | If less than one day hr. min.

9. Birthplace Barton Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Benjamin N. Bittinger
13. Birthplace Md.

MOTHER
14. Maiden Name Effie Bolman
15. Birthplace Md.

16 (a) Informant Benjamin N. Bittinger
(b) Address 800 Engine Court - Brooklyn

17 (a) Removal (b) Date thereof 12/10/45
(~~Burial, cremation~~, removal) (month) (day) (year)
(c) Cemetery or crematory Westernport
Location Md

18 (a) Funeral director William Cook, Inc
(b) Address 1217 St. Paul St.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 9 1945, at 10:55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/4 1945, to 12/9 1945, and that I last saw her alive on 12/9 1945

Immediate cause of death Massive pulmonary congestion — Duration 12 hrs

Due to Acute rheumatic fever — 2 yrs

Due to Toxic myocarditis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Massive pulmonary cong. Atherosclerosis, general

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Richard Greene Shannon, Jr. M. D.
Address University Hosps Date signed 12/9/45

VS 150

X

634933

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

634933 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 122 S Culver
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 122 S Culver Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rose Rutledge

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Landrew Rutledge
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 2-1873

8. AGE: Years	Months	Days	If less than one day
72	2	26	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name John Schmidt
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mrs Edward Whittle
(b) Address 122 S Culver Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/11/45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Balto Md

18 (a) Funeral director H S Brumbaugh & Son
(b) Address 2924 Edmondson Ave

19 (a) DEC 10 1945 (Date rec'd by registrar) Certificate for Witness Mrs

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 8 1945, at 7.50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/10 1945 to 12/8 1945, and that I last saw her alive on 12/7 1945.

Immediate cause of death: Cerebral Hemorrhage — Duration 11/29/45
" " — 5 Years
Due to General Arteriosclerosis & Hypertension — 7 Years
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Eliot W Johnson M. D.
Address 3432 Fredrick Ave Date signed

VS 3

X

MARECKI

G34934 ✓ BALTIMORE CITY HEALTH DEPARTMENT G34934

CERTIFICATE OF DEATH 160a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3200 + Calvert
(c) Hospital or institution: Union Memorial Hosp'l

(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balt.
(c) City or town Balt.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Union Mem. Hosp. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

3 (a) **FULL NAME** Baby Girl Marecki

3 (b) If veteran, name war 0 | 3 (c) Social Security Account No. 0

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife Mrs Joseph J. Marecki

6 (c) If alive, give age 25 years

7. Birth date of deceased (mo., day, yr.) 12/8/45

8. AGE: Years 0 | Months 0 | Days 0 | If less than one day 9 hr. 05 min.

9. Birthplace Union Mem. Hosp. (Town, county, and state)

10. Usual Occupation 0

11. Industry or business 0

FATHER 12. Name Joseph J. Marecki
13. Birthplace Md.

MOTHER 14. Maiden Name Mae Sophia Mazeski
15. Birthplace Balto Md.

16 (a) Informant Mother
(b) Address 428 W. Lexington Balto.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 10 45 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Fred H. Ozarowski
(b) Address 1930 Eastern Balto.

DEC 10 1945 (Date rec'd by registrar) (c) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/8/45 19..., at ... M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/7 19 45 to 12/8 19 45 and that I last saw h. alive on 12/8 19 45

Immediate cause of death Cerebral Hemorrhage.

Due to Prematurity

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operation:.....

of autopsy: No Autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ... M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....

23. Signature Wm. W. Hodges (Res Obstetrical M. D.)
Address Union Memorial Hosp. Date signed 12/F/45

X

634935

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46E

634935 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 928 E. Chase St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 928 E Chase St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Robinson Boland

3 (b) If veteran, name war: no

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Margaret J. Boland

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 12, 1897

8. AGE: Years 48 | Months 3 | Days 25 | If less than one day: hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Retired Salesman

11. Industry or business

FATHER
12. Name John J. Boland
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Susan T. Comby
15. Birthplace Baltimore Md

16 (a) Informant Mrs. Margaret J. Boland
(b) Address 928 E. Chase St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 10/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem
Location 4430 Bel Air Road

18 (a) Funeral director Elmer W. Conklin Son
(b) Address 924 E. Eager St.

19 (a) (Date received by Registrar) (b) Registrar

DEC 10 1945

Huntington for Williams, M.D.

VS-150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 7 1945, at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 2, 1945 to Dec. 7, 1945 and that I last saw him alive on Dec. 6 1945.

Immediate cause of death: Carcinoma of Sigmoid Colon — Duration:

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Samuel D. Wolfe

Address 1331 E. South Ave Date signed 12-8-45 M D

X

634936

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170C

Registered No. 634936

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4424 St. George Ave. (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elwood S. Dorsey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years 71 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location University Medical School DEC 7 1945

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) DEC 10 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

3118

MEDICAL CERTIFICATION

20. DATE OF DEATH November 30, 1945, at 6:15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Skull Fracture

Due to Intracranial Hemorrhage

Due to Rupture of Aorta.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 11-30-45 at 6:15 P.M. 27/10

(b) Where did injury occur? Bennett Place and Spring Lane

(c) Did injury occur at home, on farm, industrial place, in public place? Public. While at work? No.

(d) Means of injury Pedestrian struck by auto.

23. Signature Benedict Stetarelle M.D. Medical Examiner.

Date signed December 1, 1945.

X

PRINT WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634937

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

634937 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: John Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 917 S. Wolfe St (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Joseph Maderowski

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years	Months	Days	If less than one day
60			hr. min.

9. Birthplace.....
(Town, county, and state)
10. Usual Occupation.....
11. Industry or business.....

FATHER
12. Name.....
13. Birthplace.....

MOTHER
14. Maiden Name.....
15. Birthplace.....

16 (a) Informant.....
(b) Address.....

17 (a).....(b) Date thereof.....
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory.....
Location University Medical School DEC 7 1945 Commissioner of Health

18 (a) Funeral director.....
(b) Address.....

19 DEC 10 1945 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

3119

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/26 1945, at 8:20 P M

21. I certify that I took charge of the remains described above, held an Inspection-Inquest thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature P. J. Sulwinski M.D.
Medical Examiner.
Date signed 11/26/45

G34938

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G34938

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo. 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits write RURAL and give town)
(d) Street No. 510 Dolphin Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
45			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School DEC 7 1945
Commissioner of Health

18 (a) Funeral director
(b) Address

19 DEC 10 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 29 1945, at 10:10 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary thrombosis, left.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Richard Lee Sutton M.D.
Medical Examiner.
Date signed November 29, 1945.

VS 151

3120

G34939

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

161a

G34939 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1208 Pilot Court
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1208 Pilot Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BEATRICE RUSSELL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/2/65

8. AGE: Years | Months | Days 21 | If less than one day ..... hr. ..... min.

9. Birthplace
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location University Medical School DEC 7 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 DEC 10 1945 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/23/45 19 ..., at 7:35 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Davis M.D.
Medical Examiner.
Date signed 12/24/45

3121

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34940 ✓ G34940

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Md. General
(c) Hospital or institution: Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2hr
(e) Length of stay in Baltimore (yrs., mos., or days) 2hr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md County
(b) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 513 Linwood Ave
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Duklewski (Duklewski)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-8-45

8. AGE: Years	Months	Days	If less than one day
			2 hr. 15 min.

9. Birthplace Maryland, Balto (town, county, and state)

10. Usual Occupation Baby

11. Industry or business

FATHER 12. Name Stanley

13. Birthplace Balto, Md

MOTHER 14. Maiden Name Christine Rochowiak

15. Birthplace Balto. Md

16 (a) Informant Stanley Duklewski

(b) Address 513 S Linwood ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-10-45 (month) (day) (year)

(c) Cemetery or crematory St Stanislaus

Location Baltimore Md

18 (a) Funeral director George A Weber

(b) Address 705 S Linn st

19 (a) (Date received by registrar) DEC 10 1945 Huntington Williams, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-8 1945 at 4 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-8 1945 to 12-8 1945 and that last saw h. alive on 12-8 1945.

Immediate cause of death Prematurity — Duration 2hr 15m

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dudley Shellyer M. D.
Address Md. General Hosp. Date signed 12/15/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6349:1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1318

Registered No. 6349:1

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2902 McElderry Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 7 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2902 McElderry St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Thomas Whiteley

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Fannie Whiteley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 5, 1864

8. AGE: Years	Months	Days	If less than one day
81	9	2	hr. min.

9. Birthplace Caroline Co. Md.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name William Whiteley
13. Birthplace Md.

MOTHER
14. Maiden Name Mary E. Ornet
15. Birthplace Md.

16 (a) Informant [illegible] Whiteley
(b) Address 2902 McElderry St.

17 (a) Burial (b) Date thereof Dec. 11/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Balto. Md.

18 (a) Funeral director Philip Herwig Sons
(b) Address 2024 Orleans St.

19 (a) (b)
(Date rec'd by registrar)

VS 150 DEC 10 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 7th. 1945 at 12 20 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 16 1940 to Dec. 7 1945 and that I last saw him alive on Dec. 7 1945.

Immediate cause of death	Duration
Uraemia	5 days
Due to Chr. Nephritis	yrs
Due to	
Other Conditions Myocardial Degeneration	yrs

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature Vincent V. Dooska M.D.
Address 845 N. Patterson Pk. Date signed 12/8/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G349:2 — BALTIMORE CITY HEALTH DEPARTMENT — CERTIFICATE OF DEATH — 61 — Registered No. G349:2

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address or location: St Joseph Hosp
(c) Hospital or institution: Caroline & Oliver Sts
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1703 HANOVER ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Magdalena F Goeller (MAGDALENA F. GOELLER)

3 (b) If veteran, name war — 3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
FEM.	WHITE	WIDOW.

6 (b) Name of husband or wife JOHN GOELLER
6 (c) If alive, give age ✓ years

7. Birth date of deceased (mo., day, yr.) JULY 25 187?

8. AGE: Years	Months	Days	If less than one day
68	4	13	hr. min.

9. Birthplace GERMANY (Town, county, and state)
10. Usual Occupation HOUSE WORK
11. Industry or business AT HOME

FATHER
12. Name GEORGE HEIB.
13. Birthplace GERMANY.

MOTHER
14. Maiden Name NOT KNOWN.
15. Birthplace GERMANY.

16 (a) Informant JOHN GOELLER.
(b) Address 1703 HANOVER ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof DEC 11-45 (month) (day) (year)
(c) Cemetery or crematory HOLY CROSS
Location A.A.-Co.

18 (a) Funeral director Bernard C Harle
(b) Address 121 E West St

19 (a) (b) Huntington Williams, M.D. Registrar

DEC 10 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-8-45 19? at 4:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-24 1945 to 12-8 1945 and that I last saw h[illegible] alive on 12-7 1945.

Immediate cause of death: Respiratory failure — Duration
Due to: Cardiac failure
Due to: Heart block
Other Conditions: Diabetes mellitus
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm H. Frank
Address c/o St Joseph Hosp Date signed 12-9-45

VS 150

95a

G349:3

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

100000 G349:3 Registered No. 12c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: The Johns Hopkins Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1922 Mc Culloh Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Whalen

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Black	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 1, 1945

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Richard Whalen
13. Birthplace Maryland

MOTHER
14. Maiden Name Pearl Smallwood
15. Birthplace Maryland

16 (a) Informant Hospital Records
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical Schools DEC 7 1945 Commissioner of Health

18 (a) Funeral director
(b) Address

DEC 10 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 3 1945, at 4:40A M

21. I certify that death occurred on the date above stated; that I attended deceased from December 1 1945, to December 3 1945, and that I last saw him alive on December 3 1945.

Immediate cause of death: tuberculosis ? congenital — Duration
Due to Intrauterine infection
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Gilbert J. Vosburgh M. D.
Address Date signed

VS 150

3124 X

G34944

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G34944 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: W. B. D. H
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 da
(e) Length of stay in Baltimore (yrs., mos., or days) 12 da

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balt
(If outside city or town limits, write RURAL and give town)
(d) Street No. 243 S. Washington St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Blitz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/24/45

8. AGE: Years | Months | Days 12 | If less than one day ..... hr. ..... min.

9. Birthplace W. B. D. H
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Toby Blitz
13. Birthplace Pa

MOTHER
14. Maiden Name Helen Pauline Bagamuth
15. Birthplace Balt Md.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School DEC 7 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) DEC 10 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 5, 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-24 1945 to 12-5 1945 and that I last saw [illegible] alive on 12-5 1945

Immediate cause of death (Pneumonia (Bronchial)) — Duration

Due to

Due to

Other Conditions Premature 3-3½ weeks
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ken Heywood M. D.
Address 335 Esther Pl. Date signed 12-6-45

VS 150

3123

G34945

BALTIMORE CITY HEALTH DEPARTMENT

TM. 67953 **CERTIFICATE OF DEATH** 94a

Registered No. G34945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals 76
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 4- 3- 24 days 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. No Home
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Richardson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 12th 1870

8. AGE: Years 75 | Months 7 | Days 18 | If less than one day ..... hr. ..... min.

9. Birthplace Washington D. C
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Edwin Richardson
13. Birthplace New York

MOTHER 14. Maiden Name Josephine McThetters
15. Birthplace Ireland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School DEC 7 1945

18 (a) Funeral director Commissioner of Health
(b) Address

DEC 10 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 27th, 1945 19 , at 4.00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 3.1941, to Nov 27 19 45
and that I last saw him alive on Nov 27th 19 45.

Immediate cause of death	Duration
Coronary Thrombosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: none
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature T. P. Jerrigan M. D.
Address Baltimore City Hosp Date signed 12-5-45

VS 150

3122

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

634946

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

634946
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hosp. 8-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1907 E. 20th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George F. Rochford

3 (b) If veteran, name war	3 (c) Social Security Account No.
World War #1	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Bertha E. Rochford
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 12, 1892

8. AGE: Years	Months	Days	If less than one day
53	4	26	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Police
11. Industry or business Balto. City

FATHER
12. Name George F. Rochford
13. Birthplace Md.

MOTHER
14. Maiden Name Margaret ?
15. Birthplace Md.

16 (a) Informant Mrs. Bertha E. Rochford
(b) Address 1907 E. 20th St.

17 (a) Burial (b) Date thereof 12/11/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto. Nat'l. Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (b)
(Date received by Registrar)

DEC 10 1945

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/8 1945, at 3:25 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH coronary thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Joseph L. Sherman M.D.
Medical Examiner.
Date signed 12/8/45

X

634947

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 634947 Registered No. 937

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Garrison & Duvall
(c) Hospital or institution: Garrison Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2323 W. Lanvale St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JENNIE MAY WOODS

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Jesse Irving Woods
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 20, 1876

8. AGE: Years	Months	Days	If less than one day
69	10	17	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William Gettier
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Julia V. Beltz
15. Birthplace Md.

16 (a) Informant Mr. Jesse I. Woods
(b) Address 2323 W. Lanvale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/10/45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Signature of registrar) (b) Registrar

DEC 10 1945

VS 150

Hunting for William Mc

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 7, 1945, at 8:00 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1944 to Dec. 7 1945 and that I last saw h[illegible] alive on Dec 6 1945.

Immediate cause of death: Chronic Myocardiosclerosis — Duration

Contributory Disease

Due to arteriosclerosis

Due to

Other Conditions Uremia

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Edmund
Address 700 N. Payson Date signed 12/10/45 M. D.

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634948

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

634948

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Fayette & Payson
(b) Street address ~~2834 Alameda~~
(c) Hospital or institution:
Bon Secours Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) Co. [redacted]
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2834 Alameda
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Anna Margaret Reutter

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife John F. Reutter
6 (c) If alive, give age 64 years
7. Birth date of deceased (mo., day, yr.) Aug 5-1884
8. AGE: Years 61 Months 4 Days 2 If less than one day ..... hr. ..... min.
9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation
11. Industry or business At Home

FATHER
12. Name Henry N. Johnson
13. Birthplace Denmark

MOTHER
14. Maiden Name Julia Schmidt
15. Birthplace Germany

16 (a) Informant John F. Reutter
(b) Address 2834 Alameda
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 11 45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville
18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans St
19 (a) ..... (b) ..... (c'd by registrar) Registrar

DEC 10 1945
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/7 1945, at 7:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-3 1945 to 12-7 1945 and that I last saw h[illegible] alive on 12 [illegible] 5 1945.

Immediate cause of death	Duration
Acute coronary insufficiency —	5 days
Due to Congestive Failure	5 days
Due to Hypertension C.V.D.	—
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature T. L. Mitchell Jr
Address Bon Secours Hosp. Date signed M. 12 D. 7/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34949 — BALTIMORE CITY HEALTH DEPARTMENT — G34949

CERTIFICATE OF DEATH 46 E

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1618 Mc Elderry St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1618 Mc Elderry (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Lucy Hill

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-05-9958

4. Sex: Female

5. Color or race: Col.

6 (a) Single, married, widowed or divorced: Married

6 (b) Name of husband or wife: Joseph Hill

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1899

8. AGE: Years 46 | Months | Days | If less than one day: hr. min.

9. Birthplace Brunswick County Va. (Town, county and state)

10. Usual Occupation Housekeeper

11. Industry or business

FATHER
12. Name David Williams
13. Birthplace Virginia

MOTHER
14. Maiden Name Lucy Dawson
15. Birthplace Virginia

16 (a) Informant Charles Williams
(b) Address 1618 McElderry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/15/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location

18 (a) Funeral director Cathy Gross
(b) Address 1408 Ashland Ave

19 DEC 10 1945 (Date rec'd by registrar) Hunting Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/8 1945 at 10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1945 to Dec 8 1945, and that I last saw h[illegible] alive on Dec 8 1945.

Immediate cause of death: Carcinoma Colon — Duration: 3 mos

Due to

Due to

Other Conditions none

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ralph T. Young

Address 629 E Monument St Date signed 12/10/45

VS 2

G34950

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160c

G34950 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. State the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital 2 hrs.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 2 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5120 Ardmore Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Covington

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/8/45

8. AGE: Years | Months | Days | If less than one day: 2 hr. min.

9. Birthplace: Balto. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name: Charles C. Covington
13. Birthplace: Balto

MOTHER
14. Maiden Name: Helen Reinhardt
15. Birthplace: Balto

16 (a) Informant: Helen Covington
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/10/45 (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director: M. W. E. Dugan's Sons
(b) Address: 1500 Bond St.

DEC 10 1945

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/8 1945 at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/8 1945 to 12/8 1945 and that I last saw h. alive on 12/8 1945

Immediate cause of death: Prematurity — Duration

Due to: Placenta praevia

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Frank J. Lynch Jr.
Address: St. Joseph's Hosp. Date signed 12/8/45

VS 150

G34951 M. D. B. 1130-4 G34951

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH 13B

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1354 N. Stockton St., 11 Ward) 13

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Lenwood John C. Bailey

(a) Residence: No. 1354 N. Stockton St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Male	Col	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Mildred Bailey

6. DATE OF BIRTH (month, day, year): Jan. 18, 1927

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
21	10	22	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.: Welder

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.:

10. Date deceased last worked at this occupation (month and year):

11. Total time (years) spent in this occupation:

12. BIRTHPLACE (city or town) (State or country): Penna

FATHER

13. NAME: Lenwood Bailey

14. BIRTHPLACE (city or town) (State or country): Maryland

MOTHER

15. MAIDEN NAME: Lula Bell Maddox

16. BIRTHPLACE (city or town) (State or country): Maryland

17. INFORMANT: Lula Bell Bailey

(Address) 1354 N. Stockton St

18. BURIAL, CREMATION, OR REMOVAL

Place Ventnor, Md Date 12/12 19 45

19. UNDERTAKER: Geo. H. Kelson

(Address) 1303 Presstman St

FILED DEC 10 1945 Huntington Williams Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year): Dec. 9, 1945

22. I HEREBY CERTIFY, That I attended deceased from Oct. 29, 1945 to Dec. 9, 1945

I last saw him alive on Dec 8, 1945 Death is said to have occurred on the date stated above, at 5 A.M.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Pulmonary Hemorrhages	3 Wks

Other contributory causes of importance:

Tbc Pulmonary	

Name of operation: Date of:

What test confirmed diagnosis? Clinical Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury:

Nature of injury:

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) MacDonald Bando M. D.

(Address) 2145 Eutaw Place

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. 3

634952

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓94a

Registered No. 634952

Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

PRINT NAME PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1411 W. Lafayette Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Robert Thompson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ella

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1898

8. AGE: Years 47 | Months | Days | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name George Thompson
13. Birthplace Va.

MOTHER 14. Maiden Name Unknown
15. Birthplace ..

16 (a) Informant Ella Thompson
(b) Address 1410 Presstman St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-11-45 (month) (day) (year)
(c) Cemetery or crematory Ashland Va
Location Va

18 (a) Funeral director George A. Wilson
(b) Address 1303 Pressstman St

(a) DEC 10 1945 Huntington Williams M.D. Registrar
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 6, 19 45, at 12 30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skotarelis M.D. Medical Examiner.
Date signed 12-6-45

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634953 BALTIMORE CITY HEALTH DEPARTMENT 634953
CERTIFICATE OF DEATH 1937 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 653 W Baltimore
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 653 W Baltimore
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Jones

3 (b) If veteran, name war
3 (c) Social Security Account No.

4 Sex: Female | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife ? Jones
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 25 1846

8. AGE: Years 95 | Months 11 | Days 15 | If less than one day hr. min.

9. Birthplace Mt Meridian Md (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER 12. Name Unknown
13. Birthplace Unknown

MOTHER 14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs D Jones
(b) Address 653

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-10-41 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Balto Md

18 (a) Funeral director Mrs Robert Elliott Dft
(b) Address 1129 N. Carolina St

19 (a) DEC 10 1941 (b) Hunting for Baltimore, Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 7 1941 at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 3 1941 to Dec 7 1941 and that I last saw h alive Dec 7 1941.

Immediate cause of death Cardiac Neurosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
2 yrs

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. H. Watts M D
Address 5-156 Longfellow Date signed 12/11/41

G34954

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

106 B

G34954 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1630 Hazel St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1630 Hazel St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julian Olszewski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Not Known

8. AGE: Years	Months	Days	If less than one day
About 68			hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation B. & O. R. R.
11. Industry or business Repair car Man

FATHER
12. Name
13. Birthplace Poland

MOTHER
14. Maiden Name
15. Birthplace Poland

16 (a) Informant Julia Sokolis
(b) Address 1630 Hazel St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-11-45 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location A. A. Co.

18 (a) Funeral director Wm. J. Fialkowski
(b) Address 2007 Eastern ave

19 (a) (Date rec'd by registrar) (b) Huntingtown, Williamsport, Md.

VS 10 DEC 10 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 9 1945 at 1205 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1944 19 to Dec 6 1945 and that I last saw h alive on Dec 6 1945

Immediate cause of death	Duration
(a) Myocardial	
Due to (b) Chronic Bronchitis, Emphysema & Arteriosclerosis	1 yr
Due to (c)	
Due to (d)	

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 700 Lemmon St Date signed 12/13/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634955

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1242

Registered No. 634955

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 508 S. Port St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 508 S. Port St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Stephen Piluk Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 27/34

8. AGE: Years 11 | Months 4 3 | Days 11 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Student

11. Industry or business

FATHER
12. Name Stephen Piluk
13. Birthplace Baltimore

MOTHER
14. Maiden Name Stanislawa Burdela
15. Birthplace Baltimore

16 (a) Informant Stephen Piluk
(b) Address 508S. Port St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 11/45 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Fred W. Ozaguski
(b) Address 1930 Eastern Ave.

19 (a) Registered (b) DEC 10 1945 Registrar

Justin J. Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 7 1945, at 2 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1, 1945, to Dec. 7 1945, and that I last saw him alive on Dec. 7 1945

Immediate cause of death: Cerebral Thrombosis

Due to: Meningococcal Septicemia

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Andrew Kuzmowski M. D.

Address 2529 Eastern Date signed 12/10/45

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634956

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 E

634956 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution:
So. Balto. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 wks.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3803 Ferndale Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Evaline B. May

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-18-1636

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Clarence A. May
6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) 11/20/00

8. AGE: Years	Months	Days	If less than one day
45 4/5	-	18	hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Percy R. Brice
13. Birthplace England

MOTHER
14. Maiden Name Ella Jacobs
15. Birthplace Ohio

16 (a) Informant C. Wallace May
(b) Address 3803 Ferndale Ave.

17 (a) Burial (b) Date thereof Dec. 11, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore Md.
18 (a) Funeral director Miller Lamotray
(b) Address 4510 Liberty Heights Ave.
19 (a) (b)
(Date received by Registrar) Registrar

DEC 10 1945

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH December 8 1945, at 10:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 11, 1945, to Dec. 8, 1945, and that I last saw her alive on Dec. 8, 1945.

Immediate cause of death	Duration
Uremia	
Due to Hydronephrosis	
Due to Constriction of rectum Malignancy of Sigmoid	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph S. Arsinger
Address 1213 Light St Date signed 12-9-45

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34957

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1488

G34957 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Eutaw Place & Wilson St. Marlborough Apts.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. Marlborough Apts. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME HELEN KANN BAR.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband ~~or wife~~ Bernard Bar

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 20, 1870

8. AGE: Years	Months	Days	If less than one day
75	4	20	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation None.

11. Industry or business

FATHER 12. Name Mendel Kann.

13. Birthplace Germany.

MOTHER 14. Maiden Name Leopoldina Neuberger.

15. Birthplace Germany.

16 (a) Informant Mr. Manuel Kann.

(b) Address 3309 Leighton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12.11.45 (month) (day) (year)

(c) Cemetery or crematory Baltimore Hebrew

Location Balto. Md.

18 (a) Funeral director Chas. Sonnheim & Son

(b) Address 1902 Eutaw Place.

19 (a) (Date rec'd) DEC 10 1945 (b) Lexington Millinery M.K.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 9th. 1945 at A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1944 to Dec 9 1945 and that I last saw h[illegible] alive on Dec 8 1945

Immediate cause of death	Duration
Carcinoma of fundus uteri	
Due to	
Due to	
Other Conditions Terminal bronchopneumonia	

(Include pregnancy within 3 months of death)

Date of operation 1944

Major findings of operation: as above

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Richard D. Kahn M.D.

Address Marlborough Apts. Date signed 12/14/45

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634958

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH V 119a

634958
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1727 Madison Ave 2nd. floor
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos
(e) Length of stay in Baltimore (yrs., mos., or days) 2 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1727 Mad. Ave 2nd fl.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Verline Justus

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Fe
5. Color or race Negro
6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 3, 1945

8. AGE: Years | Months 2 | Days 4 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name Robert Justus
13. Birthplace Va

MOTHER
14. Maiden Name Lillian Justus
15. Birthplace Balto. Md.

16 (a) Informant Lillian Justus
(b) Address 1727 Mad. Ave

17 (a) Burial (b) Date thereof Dec. 10, '45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arlington Memorial
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) (b) Williams, M.D.
Registrar

DEC 10 1945
Huntington

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 7, 1945, at 8 a.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 2 1945 to Dec 7 1945 and that I last saw h[illegible] alive on Dec 7 1945.

Immediate cause of death	Duration
Marasmus	
Due to Hemorrhagic diarrhea	1 day
Due to	
Other Conditions Infant	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: Infant

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo. H. Pine Jr. M. D.
Address 1723 Druid Hill Ave Date signed 12-10-45

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634959 BALTIMORE CITY HEALTH DEPARTMENT 634959
CERTIFICATE OF DEATH 95c Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 22 S. 4th of Ave
(c) Hospital or institution:
General Human Aged People Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 22 S. 4th
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie H. Bolker

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 6. 1869

8. AGE: Years 76 | Months | Days 2 | If less than one day ____hr. ____min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name John H. Bolker
13. Birthplace Germany

MOTHER
14. Maiden Name Katherine L. Bolker
15. Birthplace Germany

16 (a) Informant Mrs. Geo. Wolz
(b) Address 22 S. Athol Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/11/45 (month) (day) (year)
(c) Cemetery or crematory Bolton
Location North Ave & Gay St

18 (a) Funeral director Henry H. Miller
(b) Address 4101 Edmondson Ave

19 (a) DEC 10 1945 (Date received by Registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 8/45. 19 10.10 A. at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 10. 45. to Dec. 8/45. and that I last saw her alive on Dec. 4/45

Immediate cause of death | Duration
Arterio-Sclerosis. | Unknown.
Due to
Due to
Other Conditions Cardiac Dilitation. 2 wks.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry Wade Chesshir M. D.
Address 930 Hanover Date signed Dec. 10/45.

VS 150

634960 BALTIMORE CITY HEALTH DEPARTMENT 634960

CERTIFICATE OF DEATH

124B Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 400 S. Robinson St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 400 S. Robinson St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Filomena Canelli

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or ~~wife~~: Giovanni Canelli
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 22 1882

8. AGE: Years	Months	Days	If less than one day
63	9	16	hr. min.

9. Birthplace Casalvecchio di Puglie Italy
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business home

FATHER
12. Name Domenico Celozzi
13. Birthplace Italy

MOTHER
14. Maiden Name Angela Maria Fratta
15. Birthplace Italy

16 (a) Informant Giovanni Canelli (Husband)
(b) Address 400 S. Robinson St.

17 (a) Burial (b) Date thereof Dec. 11 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cemetery
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Waller Hoen
(b) Address 52 N. Morley St.

19 (a) DEC 10 1945 (b) Registrar
(Date received by)

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/8 1945, at 8:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/ 1945 to 12/8 1945 and that I last saw her alive on 12/4 1945

Immediate cause of death Portal Cirrhosis — Duration 6 mos.

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank V. Manieri M. D.
Address 233 S. East Ave. Date signed 12/10/45

X MANIERI

634961

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52a

634961 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Green 3
(c) Hospital or institution University
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 D.
(e) Length of stay in Baltimore (yrs., mos., or days) 62 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balt.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 910 Eastern Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Felix Cuneo

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-18-1875

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Francis

6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) Nov. 1, 1883

8. AGE: Years	Months	Days	If less than one day
62	1	7	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Steam Fitter

11. Industry or business

FATHER 12. Name John Healy

13. Birthplace

MOTHER 14. Maiden Name Anna PETTALATA

15. Birthplace U.S.

16 (a) Informant Edward L. Healy - son-in-law

(b) Address 910 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof December 12, 45 (month) (day) (year)

(c) Cemetery ~~or Crematory~~ Holy Redeemer

Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Della Rocca

(b) Address 52 N. Morley St.

19 (a) DEC 10 1945 (Date received by registrar) Huntington Williams, M.D.

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 - 8 1945, at 10:58 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-5 1945, to 12-8 1945, and that I last saw him alive on 12 - 8 1945.

Immediate cause of death Uremia

Due to Ca. Metastatic to Lung & Prob. CA of Kidney

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 12 - 8 - 45

Major findings of operation: Metastatic CA

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo Carey M. D.

Address Univ. Hosp. Date signed 12-7-

G34962 G34962

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 833 S. Kenwood Ave
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 833 S. Kenwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Josephine Zegzdryn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	widow

6 (b) Name of husband or wife Martin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years	Months	Days	If less than one day
58			hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Dutkiewicz
13. Birthplace Poland

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Thaddeus S. Zegzdryn
(b) Address 833 S. Kenwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/13/45 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Dundalk, Ave

18 (a) Funeral director John J. Duda
(b) Address 2829 Hudson St.

19 (a) DEC 10 1945 (Date rec'd by registrar) Baltimore, Md. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 8 1945; at 11:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 8 1945, to Dec 8 1945, and that I last saw h.. alive on Dec. 8 1945

Immediate cause of death	Duration
Coronary Thrombosis	2 hrs.
Due to Arteriosclerosis	Unknown
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Clarence W. LeDoux M.D.
Address 601 S. Ellwood Ave Date signed 12/10/45

For Joseph T. Shelton, by Howard J. Stevens, M.D. X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

634963

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48 B

Registered No. 634963

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 922 - N. Eutaw St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Irene Murphy -
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: female
5. Color or race: Black
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: David Murphy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? - ? - 85.

8. AGE: Years 60 | Months | Days | If less than one day hr. min.

9. Birthplace S. C. (Town, county, and state)
10. Usual Occupation None.
11. Industry or business

FATHER
12. Name Henry Coleman
13. Birthplace S. C.

MOTHER
14. Maiden Name Daniel ?
15. Birthplace S C.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 12-12-45 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

19 (a) DEC 10 1945 (Date received by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 - 9 1945 at 8 45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12 - 1 1945 to 12 - 9 1945, and that I last saw h-- alive on 12 - 9 1945.

Immediate cause of death: Carcinomatosis peritonei — Duration
Due to: Carcinoma fundus uteri
Due to:
Other Conditions: Myoma uterus
(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation:
of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Jarma E. Davis
Address: John Hopkins Hospital Date signed: 12-10-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

634954

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 123

634954 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 31 days
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1311 Druid Hill Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bessie Chase

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: B N | 6 (a) Single, married, (widowed), or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-10-'00

8. AGE: Years 45 | Months 8 | Days 10 | If less than one day hr. min.

9. Birthplace Catonsville Md (Town, county, and state)

10. Usual Occupation Home wife

11. Industry or business

MOTHER / FATHER
12. Name Henry Chase
13. Birthplace Howard Co. Md
14. Maiden Name Elizabeth Adams
15. Birthplace Catonsville Md

16 (a) Informant Evelyn Hackett
(b) Address 1311 Druid Hill

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-11-45 (month) (day) (year)
(c) Cemetery or crematory Western Stars
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave.

19 (a) DEC 10 1945 (Date received by registrar) Hamilton Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-6 1945, at 8:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-5 1945, to 12-6 1945, and that I last saw her alive on 12-6 1945

Immediate cause of death Anemia — Duration

Due to Post transfusion anemia

Due to Operation for rectal resection

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 11-28-45

Major findings of operation: Rectal stricture

of autopsy: Congested kidneys

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J L White M. D.
Address 1514 Division St Date signed 12-10-45

G34965

BALTIMORE CITY HEALTH DEPARTMENT

HB #97600 CERTIFICATE OF DEATH ✓61

Registered No. G5295

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 70 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 641 S. Newkirk St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Hergel

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.: NONE

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Frank Hergel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 2, 1875

8. AGE: Years 70 | Months 2 | Days 7 | If less than one day hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation HOUSE WIFE

11. Industry or business AT HOME

FATHER
12. Name Conrod Ells
13. Birthplace Germany

MOTHER
14. Maiden Name ?
15. Birthplace Germany

16 (a) Informant Balto. City Hospitals (Records)
(b) Address 4940 Eastern Ave.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof DEC. 12/45 (month) (day) (year)
(c) Cemetery or crematory OAKLAWN
Location EASTERN AVE. EXT.

18 (a) Funeral director Tilley & Zeiler Inc.
(b) Address 403 S. WOLFE ST.

19 (a) (Date rec'd by registrar) (b)

VS DEC 10 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 9, 1945, at 8:AM M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 30, 1945, to Dec. 9, 1945, and that I last saw her alive on Dec. 9, 1945

Immediate cause of death: Uremia — Duration

Due to: Pyelonephritis and cystitis

Due to:

Other Conditions: Diabetes mellitus
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jonathan Hoveland M. D.
Address B. C. H. Date signed 12/9/45

133a

634966

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

634966 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 709 S. ELLWOOD AVE. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George Hartman

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NONE
4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: WIDOWER
6 (b) Name of husband or wife: CATHERINE HARTMAN
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): ? 1861
8. AGE: Years 84 | Months | Days | If less than one day ... hr. ... min.
9. Birthplace: Baltimore (Town, county, and state)
10. Usual Occupation: LABORER
11. Industry or business

FATHER
12. Name: UNKNOWN
13. Birthplace: BALTO.

MOTHER
14. Maiden Name: UNKNOWN
15. Birthplace: BALTO.

16 (a) Informant: LAYFIELD SMITH (SONIN LAW)
(b) Address: 608 S. ROBINSON ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof DEC. 11/45 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Belair Road.

18 (a) Funeral director: Lilly & Geiler Inc.
(b) Address: 403 S. WOLFE ST.

19 (a) (Date rec'd by registrar) (b) Registrar

VS DEC 10 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 8 1945, at 2:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 2 1945 to Dec 8 1945, and that I last saw him alive on Dec 8 1945

Immediate cause of death: Broncho pneumonia — Duration:
Due to: Advanced arterio-sclerotic C-V disease
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Wm. E. Wheeler
Title: Asst. Visit. Phys. Date signed: 12/9/45

634967

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30E

634967 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene Sts.
(c) Hospital or institution: Univ. Hosp. 13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 4 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balt. City
(c) City or town Baltimore 11, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3012 Darley St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James Underwood

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of husband or wife CORNIE UNDERWOOD
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) SEPT. 22 1897

8. AGE: Years	Months	Days	If less than one day
48	2	16	hr. min.

9. Birthplace TENN. (Town, county, and state)
10. Usual Occupation BURNER
11. Industry or business SHIP YARD

FATHER
12. Name JAMES J. UNDERWOOD
13. Birthplace TENN.

MOTHER
14. Maiden Name RUIE EDGMONT
15. Birthplace TENN.

16 (a) Informant JAMES W. UNDERWOOD (SON)
(b) Address 2928 E. BALTO. ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof DEC. 12/45 (month) (day) (year)
(c) Cemetery or crematory ST. MATHEWS
Location ODONNELL ST.

18 (a) Funeral director Leilly & Zeiler inc.
(b) Address 403 S. WOLFE ST.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, Md. (Registrar)

DEC 10 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-8- 1945, at 4:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1 1945 to Dec. 8 1945. and that I last saw him alive on 12-7- 1945.

Immediate cause of death	Duration
Aortic Aneurysm & pressure on Trachea Due to and erosion into Pulmonary artery	
Due to Syphilitic Cardiovascular Disease.	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm A. Holbrook, Jr. M. D.
Address Univ. Hosp. Date signed 12-8-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34968

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45F

Registered No. G34968

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 640 S. LINWOOD AVE.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 640 S. LINWOOD AVE.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EUGENE R. BANKNELL

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	SINGLE

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JAN. 10 1927

8. AGE: Years	Months	Days	If less than one day
18	10	29	hr. min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)
10. Usual Occupation LABORER
11. Industry or business CROWN CORK & SEAL CO.

FATHER
12. Name LOUIS BANKNELL
13. Birthplace ITALY

MOTHER
14. Maiden Name LAURA McDONALD
15. Birthplace BALTO. MD.

16 (a) Informant LOUIS BANKNELL (FATHER)
(b) Address 640 S. LINWOOD AVE.

17 (a) BURIAL (b) Date thereof DEC. 11/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location BELAIR ROAD
18 (a) Funeral director Lilly & Zeilenga
(b) Address 403 S. WOLFE ST.
19 (a) (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH DEC. 8 19 45 at 1/30 PM.

21. I certify that death occurred on the date above stated; that I attended deceased from March 19 45 to Dec 8 19 45, and that I last saw him alive on 12/5 19 45.

Immediate cause of death Carcinoma Throat — Duration 1 year.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation March 1945
Major findings of operation Carcinoma a. gland Neck
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature M. D.
Address 4[illegible] Belair Rd Date signed 7/10/46

DEC 1[illegible] Registrar of Vital Statistics

X

G34969 **HEALTH DEPARTMENT—CITY OF BALTIMORE** G34969

CERTIFICATE OF DEATH V119a

1. PLACE OF DEATH Bal. City Hosp

CITY OF BALTIMORE: (No. 418 W. Lexington St. Ward) 14

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ... yrs. ... mos. 7d. How long in U. S. If of foreign birth? ... yrs. ... mos. ... da.

2. FULL NAME Lawrence William Steinhauer

If U. S. Veteran specify WAR

(a) Residence: No. 206 Boyd St. St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
M	W	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, year) Nov. 24, 1945

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		14	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Balto
(State or country) Md

FATHER

13. NAME ?

14. BIRTHPLACE (city or town) ?
(State or country)

MOTHER

15. MAIDEN NAME Margaret Steinhauer

16. BIRTHPLACE (city or town) Balto
(State or country) Md

17. INFORMANT Margaret Steinhauer
(Address) 206 Boyd St.

18. BURIAL, CREMATION, OR REMOVAL
Place University Medical School Date DEC 10 1945 19

19. UNDERTAKER Commissioner of Health
(Address)

DEC 10 1945 Hattie Jean Williams M.D.
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Dec. 8, 1945

22. I HEREBY CERTIFY, That I attended deceased from Nov. 24, 1945, to Dec 8, 1945

I last saw him alive on Dec. 2, 1945 Death is said to have occurred on the date stated above, at 3.00 a.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Diarrhea - dehydration	Dec 6
Other contributory causes of importance:	

Was an operation performed? ... Date of ...

For what disease or injury? ...

Name of operation ...

What test confirmed diagnosis? ... Was there an autopsy? ...

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ... Date of injury ..., 19...

Where did injury occur? ...
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place ...

Manner of injury ...

Nature of injury ...

24. Was disease or injury in any way related to occupation of deceased?

... If so, specify ...

(Signed) Leonard Yaffe M. D.

(Address) Volunteer Gen. Hospital

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V 8

3130

X

G34970

HEALTH DEPARTMENT—CITY OF BALTIMORE G34970

CERTIFICATE OF DEATH ✓ 109a

1. PLACE OF DEATH 2nd floor Univ. Hosp.

CITY OF BALTIMORE: (No. 418 W Lafayette St., 5 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ... yrs. ... mos. ... da. How long in U. S. If of foreign birth? ... yrs. ... mos. ... da.

2. FULL NAME Wayne Robinson 17

If U. S. Veteran specify WAR

(a) Residence: No. 450 Pittman Place St., ... Ward.
(Usual place of abode)

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
M	W	

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, year) Nov. 29, 1945

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		2 d	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Baltimore Md

FATHER

13. NAME Robinson

14. BIRTHPLACE (city or town) (State or country) Fairmont W. Va.

MOTHER

15. MAIDEN NAME Marie Lavinia Smith

16. BIRTHPLACE (city or town) (State or country) Lacey Ville Pa.

17. INFORMANT Lavinia Robinson

(Address) 450 Pittman Place.

18. BURIAL, CREMATION, OR REMOVAL

Place University Medical School DEC 10 1945

19. UNDERTAKER Commissioner of Health

(Address)

DEC 10 1945 Hunter for Williams, M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Dec 7, 1945

22. I HEREBY CERTIFY, That I attended deceased from Nov. 29, 1945, to Dec 7, 1945

I last saw him alive on Dec 7, 1945 Death is said to have occurred on the date stated above, at 8.30 p. m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Coma. Virus pneumonia.	Dec 5, 1945

Other contributory causes of importance:

Was an operation performed? ... Date of ...

For what disease or injury? ...

Name of operation ...

What test confirmed diagnosis? ... Was there an autopsy? ...

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ... Date of injury ..., 19...

Where did injury occur? ...
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place ...

Manner of injury ...

Nature of injury ...

24. Was disease or injury in any way related to occupation of deceased?

... If so, specify ...

(Signed) Leonard Yaggi M. D.

(Address) Volunteer Hospital

information should be carefully supplied. state CAUSE OF DEATH in plain terms, OCCUPATION is very important. See ins

3131 X

G34971

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51B

G34971 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St
(c) Hospital or institution: St. Joseph Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3011 Belair Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Villmar

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Divorced

6 (b) Name of ~~husband or~~ wife Unknown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1891

8. AGE: Years	Months	Days	If less than one day
54			hr. min.

9. Birthplace Balto. Md
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Henry F. Villmar
13. Birthplace Germany

MOTHER
14. Maiden Name Laura Demitz
15. Birthplace Md.

16 (a) Informant Edna Threet
(b) Address 3009 Belair Rd

17 (a) Burial (b) Date thereof 12/11/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Balto
Location " Md.

18 (a) Funeral director Wilhelm Coad Inc
(b) Address 317 St. Paul St.

19 (a) DEC 10 1945 Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-9 1945 at 4:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-6 1945 to 12-9 1945 and that I last saw him alive on 12-9 1945

Immediate cause of death	Duration
Cardio-Respiratory Failure	
Due to Uremia	
Hydroureter, Intest. Ileac Stasis	
Other Conditions Carcinoma of Prostate + Hydro Nephrosis Bilateral	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Clarence M. Mahin, M.D.
Address 5 Joseph's Hosp Date signed 12 Dec 45

CLARENCE M. MAHIN, M.D.

VS 150

634972

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157E

Registered No. 634972

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N.J. (b) County
(c) City or town Bayonne (If outside city or town limits, write RURAL and give town)
(d) Street No. 183 W. 48th St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Harriett Goldstein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-16-25

8. AGE: Years 20 | Months 7 | Days 24 | If less than one day hr. min.

9. Birthplace N.J. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Herman Goldstein
13. Birthplace Romania

MOTHER 14. Maiden Name Lillian Marken
15. Birthplace Romania

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) removal (Burial, cremation, or removal) (b) Date thereof 12-10-45 (month) (day) (year)
(c) Cemetery or crematory
Location Jersey City N.J.

18 (a) Funeral director Jeff. Peters & Co
(b) Address 1459 E. Baltimore St

DEC 11 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 10 1945 at 12:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 5 1945 to Dec 10 1945, and that I last saw h alive on Dec 10 1945.

Immediate cause of death	Duration
Cerebral asphyxia	
Due to Anaesthetic complications	
Due to	
Other Conditions Tetralogy of Fallot	

(Include pregnancy within 3 months of death)

Date of operation 12-10-45

Major findings of operation: Tetralogy of Fallot

of autopsy: Same.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. A. Cooley M. D.
Address The Johns Hopkins Hospital Date signed 12-10-45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34973

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G34973

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos. or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County Washington
(c) City or town Hagerstown (If outside city or town limits, write RURAL and give town)
(d) Street No. 404 Ridge Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Clarence Kepler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: ~~Mary Brandenburg~~ Ethel Virginia Kepler (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/ 1898

8. AGE: Years 47 | Months 7 | Days | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Truck driver

11. Industry or business

FATHER
12. Name Harry Kepler
13. Birthplace Maryland

MOTHER
14. Maiden Name May Brandenburg
15. Birthplace Maryland

16 (a) Informant Ethel Green mother
(b) Address 404 Ridge ave Hagerstown Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 (month) 13 (day) 1945 (year)
(c) Cemetery or crematory Greenmount
Location Sharpsburg Pike

18 (a) Funeral director Edie & Hoffmeister
(b) Address Williamsport Md

DEC 11 1945 (Date received by local registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 10th 1945, at 6:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 3 1945, to Dec 10 1945, and that I last saw him alive on Dec. 10 1945

Immediate cause of death: Subdural Hemorrhage — Duration: 7 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Subdural Hemorrhage

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thos. E. Wheeler, M. D.
Address South Balto. Gen. Hosp. Date signed 12/13/45

G34974

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G34974
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2338 Druid Hill Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2338 Druid Hill Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lucy Holden Berry

3 (b) If veteran, name war
3 (c) Social Security Account No.
4 Sex Female
5. Color or race Col.
6 (a) Single, married, widowed, or divorced Widowed
6 (b) Name of husband or wife Martin
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) June 5, 1884
8. AGE: Years 61 Months 6 Days 3 If less than one day min.
9. Birthplace Glam, Va (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Thornton Garrett
13. Birthplace Glam, Va

MOTHER
14. Maiden Name Alice Harris
15. Birthplace Glam, Va

16 (a) Informant Alice Berry
(b) Address 2338 Druid Hill Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 10, 1945 (month) (day) (year)
(c) Cemetery or crematory Family Lot
Location Glam Va
18 (a) Funeral director Chas. H. Hellen
(b) Address 1631 Druid Hill Ave

DEC 11 1945 (Date rec'd by registrar)
(b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 8 1945, at 1A M
21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1945 to Dec 8 1945; and that I last saw h. alive on Dec 7 1945.

Immediate cause of death: Acute Myocardial infarction — Duration
Due to: Coronary Thrombosis
Due to:
Other Conditions: Diabetes Mellitus
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature [illegible]
Address 4546 Reed Date signed 12/10/45

94a

VS 150

634975

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

158

634975 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution: University Hospital 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 29 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 269 Dallas Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Andryniak

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 2 - 1945

8. AGE: Years	Months	Days	If less than one day
	1	8	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Walter Herman Andryniak
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Virginia Lundy
15. Birthplace Va

16 (a) Informant Walter H Andryniak
(b) Address 269 Dallas court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-11-45 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Baltimore Md
18 (a) Funeral director George A Weber
(b) Address 705 S Ann st
19 (a) DEC 11 1945 (Registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/10 1945, at 3:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/11 1945 to 12/10 1945, and that I last saw her alive on 12/10 1945.

Immediate cause of death	Duration
Cardio - Respiratory Failure	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John M. Dennis
Address University Hospital Date signed 12/10/45

VS 150

634976

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 634976

MARGIN RESERVED FOR BINDING

Every item of information should be carefully supplied. Please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 305 S. Wolfe St
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Kamasinski (or) Kamosa

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Julia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-16-85

8. AGE: Years	Months	Days	If less than one day
60	9	21	hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ? ?
13. Birthplace Poland

MOTHER
14. Maiden Name ? ?
15. Birthplace Poland

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 12-12-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory ST. STANISLAUS
Location Baltimore Md.

18 (a) Funeral director George A. Weber
(b) Address 705 S Conn at

19 (a) 1 1945 Huntington Williams M.D.
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 7 1945 at 11.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 7 1945 to Dec 7 1945 and that I last saw him alive on Dec. 7 1945.

Immediate cause of death coronary thrombosis — Duration 2 days

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John Saint Williams M.D.

Address Johns Hopkins Hosp Date signed 12/10/45

X

G34977

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G34977 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 215 S. Fulton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 215 S Fulton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary A. Hepburn

3 (b) If veteran, name war: No

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Patrick J. Hepburn

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 27, 1862

8. AGE: Years	Months	Days	If less than one day
82	11	11	12 hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business at Home

FATHER
12. Name John Collart
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Not Known
15. Birthplace ? ?

16 (a) Informant Mrs. Genevieve Koglmle
(b) Address 215 S. Fulton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 14, 1945 (month) (day) (year)
(c) Cemetery or crematory Western Cemetery
Location Edmondson Ave at Longwood St

18 (a) Funeral director Edmund W. Conkling & Son
(b) Address 924 E. Eager St.

DEC 11 1945 (Date rec'd by registrar) Hunter for Williams Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 8, 1945, at 8:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/17 1942 to 12/8 1945.
and that I last saw h[illegible] alive on 12/8 1945.

Immediate cause of death
Pulmonary Edema — Duration 12 D
Due to Myocarditis
Due to
Other Conditions Arteriosclerosis
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James W. Catzenberger M.D.
Address 1 W Mulberry St Date signed 12/10/45

JAMES W. CATZENBERGER M.D.

G34978

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. G34978

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2361 Mc Culloh St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2361 Mc Culloh St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Howard C. Wright

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Florence

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 9, 1889

8. AGE: Years 56 | Months 7 | Days 28 | If less than one day hr. min.

9. Birthplace Balto Md. (Town, county, and state)

10. Usual Occupation Teacher

11. Industry or business Public School

FATHER
12. Name Calvin Wright
13. Birthplace Tappahannock, Va

MOTHER
14. Maiden Name Mary Egerton
15. Birthplace Balto Md.

16 (a) Informant Florence Wright
(b) Address 2361 Mc Culloh St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 11, 1945 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. Geo. H. Fuller
(b) Address 1431 Druid Hill Ave.

19 (a) 11 1945 (Date rec'd by registrar) Interstate for Williams M.T. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/7 1945, 12:30 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 11.24 1945, to Dec 7 1945, and that I last saw h alive on Dec 6 1945.

	Duration
Immediate cause of death: Lobar Pneumonia	2 wks
Due to:	
Due to:	
Other Conditions: Cardiac failure	6 days

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. P. Hughes M. D.
Address 825 N. Eutaw Date signed 12/10/45

VS 150

G34979

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G34979 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1424 W. Lexington St.
(c) Hospital or institution: Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5406 Reedy Av (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Mary E. B. Sproul

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife George E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 18-1863

8. AGE: Years 82 | Months 10 | Days 22 | If less than one day hr. min.

9. Birthplace Balto. (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Portner
13. Birthplace Dont Know

MOTHER'S
14. Maiden Name
15. Birthplace

16 (a) Informant Anthony J. Bitter
(b) Address 1412 Woodyside Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 12-45 (month) (day) (year)
(c) Cemetery or crematory Mem. Park.
Location Old Frederick Rd.

18 (a) Funeral director Jos. A. Jordan
(b) Address 300 E. Balto. St.

DEC 11 1945 (Date received by Registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 9 1945, at 7:00 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 3 1945, to Dec 9 1945, and that I last saw h[illegible] alive on Dec 9 1945.

Immediate cause of death: Cerebral Embolism — Duration 10 yrs.
Due to: Chr. Myocarditis — 10 yrs.
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Megrue L. Soloman M. D.
Address 129 S. Bway Date signed 12/10/45

G34950

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55c

Registered No. G34950

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be sure correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2211 Rogers Ave
(c) Hospital or institution: Aged Home of M.E. Church
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2211 Rogers Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Riley

3 (b) If veteran, name war —
3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	White	Widow

6 (b). Name of husband or wife Nelson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 6, 1856

8. AGE: Years	Months	Days	If less than one day
89	8	5	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation none
11. Industry or business

PARENTS
12. Name of father William Kagle
13. Birthplace Germany
14. Maiden Name of mother Sophonia Hartman
15. Birthplace Germany

16 (a) Informant A. D. Savage
(b) Address 2211 Rogers Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/12/45 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Baltimore Md

18 (a) Funeral director Wilson Cook Inc
(b) Address 1219 E Fort Ave

DEC 11 1945 (c) (Date received by Registrar) (Signature of Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-11 1945 at 2.15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from JAN 1 1945 to Dec 9 1945 and that I last saw h[illegible] alive on Dec 9 1945

Immediate cause of death	Duration
Myocardial Insufficiency	4 days
Due to Coronary Thrombosis	15 Mos.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Arthur J Davis M. D.
Address 1003 Eutaw St Date signed 12/14/45

VS 150

G34981

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

Registered No. G34981

481.642

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Johns Hopkins Hospital
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL Monument & Broadway
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3506 Springdale Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marie A. Silberstein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	married

6 (b) Name of husband or wife Louis M.

6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) 6-10-99

8. AGE: Years	Months	Days	If less than one day
46.	5	29	hr. min.

9. Birthplace Mass.
(Town, county, and state)

10. Usual Occupation Home wife

11. Industry or business

FATHER
12. Name Nahum Adlin
13. Birthplace Russia

MOTHER
14. Maiden Name Anna Lohrentroff
15. Birthplace Russia

16 (a) Informant Friends
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof December 11, 1945 (month) (day) (year)
(c) Cemetery or crematory Beth Tfiloh Cemetery
Location Windsor Mill Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

DEC 1 1945 (Date rec'd by Registrar) (Huntington Williams, M.D.) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 9 1945 at 7:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 5 1945 to Dec. 9 1945 and that I last saw h.. alive on Dec. 9 1945.

	Duration
Immediate cause of death cachexia & exhaustion	
Due to generalized metastatic carcinoma	18 mos
Due to primary carcinoma of breast	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address Johns Hopkin Hosp. Date signed 12-9-45

X

G34982 HEALTH DEPARTMENT—CITY OF BALTIMORE G34982

CERTIFICATE OF DEATH

937

Registered No.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1906 W. Baltimore, / Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME John H. Reinhardt V

If U. S. Veteran specify WAR

(a) Residence: No. 1906 W. Baltimore St., Ward 557-218-09-2210
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male | 4. Color or Race: White | 5. Single, Married, Widowed, or Divorced (write the word): Married

5a. If married, widowed, or divorced — HUSBAND of (or) WIFE of: Catherine A.

6. DATE OF BIRTH (month, day, year): 5 July 1868

7. AGE — Years: 77 | Months: 5 | Days: 2 | If LESS than 1 day, hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.: Retired Coachman

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.: Retired Army Officer

10. Date deceased last worked at this occupation (month and year): 2-18-09 | 11. Total time (years) spent in this occupation: 36

12. BIRTHPLACE (city or town) (State or country): Baltimore Maryland

FATHER

13. NAME: John A. Reinhardt

14. BIRTHPLACE (city or town) (State or country): Germany

MOTHER

15. MAIDEN NAME: Mary Wagner

16. BIRTHPLACE (city or town) (State or country): Germany

17. INFORMANT: Mrs. Catherine A. Reinhardt
(Address) 1906 W. Baltimore St.

18. BURIAL, CREMATION, OR REMOVAL
Place London Park Date 11 DEC. 45 19..

19. UNDERTAKER: F. B. Wisbert & Son
(Address) 1700 Eutaw Place

DEC 11 1945 Huntington Williams M.D.
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year): 12/9, 1945

22. I HEREBY CERTIFY, That I attended deceased from 1/17, 1941 to 12/9, 1945

I last saw him alive on Dec. 9, 1945 Death is said to have occurred on the date stated above, at 10:35 P.M.

The principal cause of death and related causes of importance were as follows:

	Duration
Cerebral Hemorrhage	4 days
Arterio Sclerosis	(a)
Myocardial Degeneration.	(b)
Other contributory causes of importance: Benign Prostatic Hypertrophy 3rd°	

Was an operation performed? Date of

For what disease or injury?

Name of operation

What test confirmed diagnosis? Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? Date of injury, 19..

Where did injury occur?
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify

(Signed) Samuel G. Gayford M. D.
(Address) 1905 W. Balt. St.

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

VS 3

G34983

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937 Registered No. G34983

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4205 Parkmont Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days) 43 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4205 Parkmont Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZABETH STUMPFEL

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Joseph Stumpfel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 12,1868

8. AGE: Years 77 | Months 8 | Days 27 | If less than one day hr. min.

9. Birthplace Austria (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name -- Ritter
13. Birthplace Austria

MOTHER
14. Maiden Name Unknown
15. Birthplace Austria

16 (a) Informant Mr. Wm. C. Stumpfel
(b) Address 4205 Parkmont Ave.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof Dec. 12, 1945 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto., Md.

18 (a) Funeral director Leasche & Funeral Home
(b) Address 7401 Belair Road
(c) [illegible]

DEC 11 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 9th, 1945 12:36 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1945 to Dec 9 1945 and that I last saw h[illegible] alive on Dec 8 1945

Immediate cause of death: Cerebral Hemorrhage
Due to: [illegible]
Due to: Arterial Sclerosis
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operations:
of autopsy:

Duration: 6 mos. / Yrs.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:
23. Signature: [illegible] M.D.
Address 720 E 33rd St Date signed 12/10/45

VS 150

634984

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52a

Registered No. 634984

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 49 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2016 Orleans St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LOUIS BERLIN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W.	married

6 (b) Name of husband or wife Anna Berlin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years	Months	Days	If less than one day
58			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name Elig-
13. Birthplace Russia

MOTHER
14. Maiden Name Maryam H-
15. Birthplace Russia

16 (a) Informant Annie Berlin
(b) Address 2016 Orleans St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-11-45 (month) (day) (year)
(c) Cemetery or crematory Northern Ave
Location

18 (a) Funeral director Jack Louis Inc
(b) Address 1437 E. Baltimore St

19 (a) DEC 11 1945 (Date rec'd by registrar) (b) Livingston Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH DEC 10 1945 at 1300 M

21. I certify that death occurred on the date above stated; that I attended deceased from DEC 3 1945 to DEC 10 1945 and that I last saw him alive on DEC 10 1945

Immediate cause of death	Duration
Cardiac Failure	
Due to Coronary Heart Disease	
Bronchopneumonia, left.	
Due to	
Other Conditions Generalized metastasis Carcinoma Left Kidney	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Metastasis; bronchopneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis H Tarlow M. D.
Address Sinai Hospital Date signed 12/10/45

G34985 G34985

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 42a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rukeland & Rayner
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5756 Cordelia Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Nathan Jacobson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1868

8. AGE: Years	Months	Days	If less than one day
77			hr. min.

9. Birthplace Dublin, Ireland
(Town, county, and state)

10. Usual Occupation Paper Hanger

11. Industry or business

FATHER
12. Name Morris B.
13. Birthplace Russia

MOTHER
14. Maiden Name Luby
15. Birthplace Russia

16 (a) Informant Mrs. Nathan Weinel
(b) Address 617 St. Paul St

17 (a) Burial (b) Date thereof 12-11-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Hebrew Friendship
Location

18 (a) Funeral director Jack Levin
(b) Address 1439 E. Balto. St

19 DEC 11 1945 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/10 1945, at 7 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/6 1945 to 12-10 1945 and that I last saw h[illegible] alive on 12-10 1945.

Immediate cause of death Pulmonary edema

Due to Congestive Heart failure

Due to Rheumatic Cardio Vascular disease - Mitral & Aortic stenosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chas. H. Baldwin M. D.
Address West Baltimore General Hosp. Date signed 12-10

VS 150

634986

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. 634986

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greene St
(c) Hospital or institution: University Hospt
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balt. City
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3427 Park Heights Av
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Abraham Wagenheim

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widow

6 (b) Name of husband or wife Jenna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1871

8. AGE: Years	Months	Days	If less than one day
74			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Hospt Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-11-45 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location Baltimore & Conkling Sts

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Baltimore St.

DEC 11 1945 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-11-1945, at 5 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-6-1945, to 12-11-1945, and that I last saw h.. alive on 12-11-1945.

Immediate cause of death	Duration
Cerebrovascular Accident, Hemorrhage	
Due to Hypertensive Degenerative Cardiovascular Disease	
Other Conditions Senile Dementia	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. J. Holbrook M.D.

Address Univ. Hosp. Date signed 12-11-45

634987 — for R.I. Yearbook — 634987

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 662 W. Franklin St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 662 W. Franklin St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Nathaniel Randall

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex M | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Child

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-20-1943

8. AGE: Years | Months 3 | Days 21 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name Mary Randall
15. Birthplace Md

16 (a) Informant Mary Randall
(b) Address 662 W. Franklin St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 12 45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore Md

18 (a) Funeral director Williams & Jackson
(b) Address 616 Penna Ave

DEC 11 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 10 1945, at 8 a.m. P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/5 1945, to 12-10 1945, and that I last saw h alive on 12-10 1945.

Immediate cause of death: Intra pneumonia — Duration 11 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. Hamman M. D.
Address 600 Cathedral Date signed 12/11

X

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

34988

BALTIMORE CITY HEALTH DEPARTMENT

HB# 64909

CERTIFICATE OF DEATH

937

Registered No. 634988

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 8 7
(e) Length of stay in Baltimore (yrs., mos., or days) 10 years

26-12

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. No Home
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anzie Woods
Anzie Woods

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	C	Separated

6 (b) Name of husband or wife Unire
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 15, 1900

8. AGE: Years	Months	Days	If less than one day
45	7	14	hr. min.

9. Birthplace South Carolina
(Town, county, and state)
10. Usual Occupation Laborer.
11. Industry or business

FATHER
12. Name ? Chris Woods
13. Birthplace ? S. C.

MOTHER
14. Maiden Name Mattie Foot
15. Birthplace ? S C.

16 (a) Informant Balto. City Hospitals (Records)
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 12 12 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem Park
Location Arbutus Md

18 (a) Funeral director William A Jackson
(b) Address 916 Pennsylvania Ave

19 DEC 11 1945 Huntington Williams M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 9, 1945 at 5:14 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 2, 1941, to Dec. 9, 1945 and that I last saw h. im alive on Dec. 9, 1945.

Immediate cause of death Pneumonia — Duration 7

Due to Hypertensive Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: none

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature T. P. Jenigon M. D.
Address Baltimore City Hosp. Date signed 12-9-45

B34939 484742

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

124 B ✓ Registered No. B34939

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 15

(d) Length of stay in hospital or inst. (yrs., mos., or days) .....
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 614 Gold St. (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Rosia Tines

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Katie

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 12-25-85

8. AGE: Years 60 | Months 11 | Days 15 16 | If less than one day ..... hr. ..... min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Janitor

11. Industry or business

FATHER
12. Name Clifton Tines
13. Birthplace Va

MOTHER
14. Maiden Name Malinda ?
15. Birthplace Va

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-13-45 (month) (day) (year)
(c) Cemetery or crematory Halls Cemetery
Location A. A. County Md.

18 (a) Funeral director William A Jackson
(b) Address 916 Pennsylvania Ave

19 DEC 11 1945 [illegible] Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec - 10 - 1945, at 2.50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec - 4 1945 to Dec - 10 1945, and that I last saw him alive on Dec - 10 1945

Immediate cause of death: Septicemia due to unknown organism.

Duration: 24 HRS.

Due to ?

Due to .....

Other Conditions: Cirrhosis of Liver, Ascites.
(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of ~~operation~~ autopsy: Cirrhosis of Liver, Splenomegaly, Septicemia

~~of autopsy~~:

UNKNOWN

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? .....
(e) Means of injury .....

23. Signature Theodore D Stephens M. D.
Address Johns Hopkins Hospital Date signed 12/10/45

X

634990

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 634990

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Special attention is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 6706 Old Harford Rd.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 6706 Old Harford Rd.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine M. Krebs

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife John T. Krebs

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 4 1875

8. AGE: Years	Months	Days	If less than one day
70	8	4	hr. min.

9. Birthplace Brooklyn N.Y.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Unknown (Sellers)

13. Birthplace "

MOTHER 14. Maiden Name "

15. Birthplace "

16 (a) Informant Mrs. Ann Disney

(b) Address 6706 Old Harford Rd.

17 (a) Burial (b) Date thereof Dec. 11, 45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Parkwood Mem.

Location Taylor Ave.

18 (a) Funeral director L. Leemann and Son

(b) Address 32 S. Broadway

19 DEC 11 1945 Huntington Williams, M.D.
(Date rec'd by local reg.) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 8 19 45 at 9:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1945 to Dec 8 1945 and that I last saw him alive on Dec 7 19 45.

Immediate cause of death	Duration
Coronary Thrombosis.	Stat
Due to Arteriosclerosis — arterial Hypertension	
Due to	
Other Conditions —	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence — at M

(c) Where did injury occur? —
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)

(e) Means of injury

23. Signature Louis F. Leemann M. D.

Address 732 N. Howard St. Date signed Dec 10/45

VS 150

634991

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

9-37

634991 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution:
Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 37 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto. City
(c) City or town 3017 Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3016 Gibbons Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

3 (a) FULL NAME Melchoir Armistead Tracey — Melchoir Armacost Tracey

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	213-05-4582

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	wh.	Married

6 (b) Name of husband/wife Marion M Tracey
6 (c) If alive, give age 41 years

7. Birth date of deceased (mo., day, yr.) March 2, 1908

8. AGE: Years	Months	Days	If less than one day
37	9	8	hr. ..... min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Salesman & Collector
11. Industry or business Md. News Co

FATHER
12. Name Charles G Tracey
13. Birthplace Maryland

MOTHER
14. Maiden Name Addie V. Martin
15. Birthplace Maryland

16 (a) Informant Mrs Marion Tracey
(b) Address 3016 Gibbons Ave - Balto

17 (a) Burial (b) Date thereof Dec. 13, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Black Rock
Location Balto. Co. Md.

18 (a) Funeral director Wm. J. Tickner & Sons, Inc.
(b) Address North & Pa. Aves.

DEC 11 1945 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec - 10 - 1945, at 2:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 9 1945 to Dec - 10 1945, and that I last saw h.. alive on Dec - 10 - 1945.

Immediate cause of death: Cerebro - Vascular Accident — Duration

Due to Hypertensive Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George H. Schleunger M. D.
Address Date signed 12/10/45

VS 150

Schleunger

G34992

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G34992

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3329 Edmondson Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3329 Edmondson Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: AUGUSTA E. HAMMOND

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife: Frederick J. Hammond
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 27, 1864

8. AGE: Years	Months	Days	If less than one day
81	0	11 10	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name August Lange
13. Birthplace Germany

MOTHER
14. Maiden Name Marie Bruns
15. Birthplace Germany

16 (a) Informant Mr. Nelson Hammond
(b) Address 3329 Edmondson Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/11/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Balto., Md.

18 (a) Funeral director M. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) D.C. 1-1-1946 (Date received by Registrar) Registrar

MEDICAL CERTIFICATION P.

20. DATE OF DEATH Dec. 7, 1945, at 11:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 8 1945 to Dec 7 1945 and that I last saw h[illegible] alive on Dec 7 1945

Immediate cause of death Cerebral Hemorrhage — Duration Dec 7, 1945

Due to

Due to

Other Conditions Arteriosclerosis — Nov 7, 1945

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature L. E. Talley M. D.
Address 3512 Edmondson Ave. Date signed Dec 8, 1945

VS 150

X

G34993 ✓ G34993

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden and Madison Ave.
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 9 weeks

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 729 N. Fulton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Judith Eileen Robinson

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: infant

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 5, 1945

8. AGE: Years | Months: 2 | Days: 5 | If less than one day: hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Jesse Arnold Robinson
13. Birthplace Baltimore

MOTHER
14. Maiden Name Audrey Hegele
15. Birthplace Baltimore

16 (a) Informant Mr. Jesse A. Robinson
(b) Address 729 N. Fulton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/12/45 (month) (day) (year)
(c) Cemetery or crematory Moreland Memorial
Location Taylor Ave. Balto. Md.

18 (a) Funeral director Wm. J. Tickner & Sons Inc.
(b) Address North & Pa. Aves. Balto.

19 DEC 11 1945 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 10th 1945, at 5 10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/10 1945 to 12/10 1945, and that I last saw her alive on 12/10/1 1945

Immediate cause of death unknown — Duration

Due to Pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. E. Nobel M. D.

Address Maryland G. Hospital Date signed 12/10/45

X

634994

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

Registered No. 634994

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 414 Bretton Place
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 414 Bretton Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lula B. Cranmer

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 6, 1877

8. AGE: Years	Months	Days	If less than one day
68	2	3	hr. min.

9. Birthplace N. J.
(Town, county, and state)
10. Usual Occupation Buyer
11. Industry or business The Regal Shop

FATHER
12. Name Capt. Thomas C. Cranmer
13. Birthplace N. J.

MOTHER
14. Maiden Name Abbie P. Dye
15. Birthplace N. J.

16 (a) Informant Mrs. Eva P. Fry
(b) Address 3302 Otis St. Mt. Ranier,

17 (a) Burial (b) Date thereof 12/12/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director Wm. J. Tickner & Sons, Inc.
(b) Address North & Pa. Aves.

(a) Date received by Registrar DEC 11 1945 Livingston Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION P

20. DATE OF DEATH December 9, 1945, at 10:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 8 1940 to Dec 9 1945 and that I last saw alive on Dec 6 1945

Immediate cause of death Carcinoma of Stomach — Duration About 6 mo

Due to

Due to Carcinoma of Stomach

Other Conditions Secondary anemia — 3rd
(Include pregnancy within 3 months of death)

Date of Operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter S. Tibbitt M. D.
Address 2220 Garrison Blvd Date signed Dec 11/45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G34995 CERTIFICATE CORRECTED 12-20-44 ✓ G34995

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3100 Ferndale Aves.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3100 Ferndale Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Adelaide B. Meushaw

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow MEUSHAW

6 (b) Name of husband or wife Merrill Meushaw
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 3, 1857

8. AGE: Years	Months	Days	If less than one day
88	3 4	6	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Thomas Y. Foster
13. Birthplace New Haven Conn.

MOTHER
14. Maiden Name Almira N. Stanley
15. Birthplace N. C.

16 (a) Informant Miss Myrtle Meushaw MEUSHAW
(b) Address 3100 Ferndale Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 12, 1945 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Windsor Mill Rd. Woodlawn, Md.

18 (a) Funeral director Wm. J. Tickner Sons, Inc.
(b) Address North & Pa. Aves.

DEC 11 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH December 9, 1945, at 12:05 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 5 1945 to Dec 8 1945, and that I last saw h[er] alive on Dec 8 1945.

Immediate cause of death	Duration
Cardio-Vascular-nephritis	
Due to Senility	24 days
Due to Age	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury —

23. Signature M. Bauman and Hood M. D.
Address 2200 Garrison Blvd Date signed 12-10-45

X

634996

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945 B

634996 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Beech Ave. & 40th Sts
(c) Hospital or institution:
Wyman Park Apartments 13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Beech & 40th Sts,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harold M. Moat

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	213-05-9875

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife Single
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 18, 1887

8. AGE: Years	Months	Days	If less than one day
58	0	20	hr. min.

9. Birthplace Lee, Mass.
(Town, county, and state)
10. Usual Occupation Retired Supt. Underground Cable
11. Industry or business Balto. Transit Co.

FATHER
12. Name Thomas Moat
13. Birthplace Albany, N. Y.

MOTHER
14. Maiden Name Margaret Gowan
15. Birthplace Albany, N. Y.

16 (a) Informant Mrs. Cora L. Hanna
(b) Address 133 Exchange Rochester, N. Y.

17 (a) Burial (b) Date thereof Dec. 11, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Windsor Mill Rd. Woodlawn

18 (a) Funeral director Wm. J. Tickner & Sons, Inc.
(b) Address North & Pa. Aves.

DEC 11 1945 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 8, 1945, at 2:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from OCT 4 1945 to DEC 8 1945 and that I last saw him alive on DEC 8 1945

Immediate cause of death	Duration
Angina Pectoris	10/4/45
Due to Atherosclerosis	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hugh D. Bukert M. D.
Address 5603 Park Heights Ave Date signed 12/10/45

VS 180

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

63497 — BALTIMORE CITY HEALTH DEPARTMENT — 63497

CERTIFICATE OF DEATH ✓ 94a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Foot of Clinton Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County Balto.
(c) City or town Lansdowne
(If outside city or town limits, write RURAL and give town)
(d) Street No. 161 Howard Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph George Moore

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Margaret Moore

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 12, 1898

8. AGE: Years	Months	Days	If less than one day
46	11	28	hr. min.

9. Birthplace Roanoke, Virginia
(Town, county, and state)

10. Usual Occupation Lawyer

11. Industry or business

MOTHER / FATHER

12. Name George Moore

13. Birthplace Virginia

14. Maiden Name Hannah Callahan

15. Birthplace Virginia

16 (a) Informant Mrs. C. G. Norris (Brother-in-law)

(b) Address 3028 Virginia Ave. Ruby

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec/13/45 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge Cemet.

Location Pikesville, Md

18 (a) Funeral director Stewart & Mowen Co.

(b) Address 108 W. North Ave., Balto 1, Md.

19 DEC 11 1945 (Date received by registrar) Thurlington for Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 10 1945, at 10:55 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skitarski M.D.
Medical Examiner.
Date signed

G34998

484624

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 24a

G34998 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: [illegible] HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 1/3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 119 N. Madeira St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Randolph.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male.

5. Color or race: Black.

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Ada.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-28-92

8. AGE: Years 53. Months 9 Days 10 If less than one day hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation Laborer.

11. Industry or business

FATHER
12. Name Peter Randolph
13. Birthplace ?, ?.

MOTHER
14. Maiden Name ?, ?.
15. Birthplace ?.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 12/12/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1900 Brant Square

DEC 11 1945 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 8 - 1945, at 1.45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 2 1945, to Dec. 8 1945, and that I last saw him alive on Dec. 8 1945.

Immediate cause of death — Duration

Septicemia, Cause not determined.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Philip A. Lamatt

Address Johns Hopkins Date signed 12-8-45

correct age is especially important. Physicians; please write the causes of death clearly and legibly.

23 1999 DANDY

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G34999

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3136 Hawick Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 D
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3136 Hawick Road.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John W. Sandy.

3 (b) If veteran, name war – | 3 (c) Social Security Account No. –

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	marr'd

6 (b) Name of husband or wife Rose M. Sandy.
6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) Oct 2, 1879

8. AGE: Years	Months	Days	If less than one day
66	2	2	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Joseph Sandy
13. Birthplace Maryland.

MOTHER
14. Maiden Name Mary Swann.
15. Birthplace Maryland.

16 (a) Informant Rose M. Sandy
(b) Address 3136 Hawick Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 12/45 (month) (day) (year)
(c) Cemetery or crematory Moreland Park.
Location Taylor Ave

18 (a) Funeral director Edmund P. Donovan
(b) Address 3615-17 Chestnut Ave

19 (a) DEC 1945 (Date rec'd by Registrar) (b) Hunter for Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 9 1945, at 9:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1945, to Dec 9 1945, and that I last saw h alive on 12/5 1945.

Immediate cause of death	Duration
carcinoma colon	4 yrs.
Chronic colitis	
Due to	
Due to	
Other Conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward H. Stone
Address 2020 N. Charles Date signed 12/9/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G35000

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G35000 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 W. 40th St.
(c) Hospital or institution: Home for Incurables
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 13
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 700 W. 40th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Patrick Joseph Lyston Lyston

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	Married

6 (b) Name of husband or wife Ethel Sr. Lyston

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 14, 1875

8. AGE: Years	Months	Days	If less than one day
70	10	26	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Michael Lyston
13. Birthplace Ireland

MOTHER
14. Maiden Name Isabelle Rice
15. Birthplace Newfoundland

16 (a) Informant Home for Incurable records
(b) Address 700 W. 40th St. Balto. Md. MEO

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/12/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director W. A. Mears & Son
(b) Address 805 N. Calvert St.

19 DEC 11 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 10, 1945 at 2:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 27 1945 to Dec. 10 1945 and that I last saw h[illegible] alive on Dec. 9 1945

	Duration
Immediate cause of death: Myocardial Insufficiency	1 week
Due to: Arteriosclerotic Cardio-Vascular Disease	Several years
Due to:	
Other Conditions: Widespread Arteriosclerosis	18 years

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas Conrad Wolf, M.D.
Address 11 E. Chase St. Baltimore 2, Maryland
Date signed 12/10/45

63500 L

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

63,001 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 335 Yale Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ---
(e) Length of stay in Baltimore (yrs., mos., or days) 50 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County ---------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 335 Yale Avenue . Irvington
(If rural give location)
(e) Citizen of foreign country? ------- (Yes or No)
If yes, name country ------

3 (a) FULL NAME William Bosley Hall

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Beulah Truehart
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) -------- 1871

8. AGE: Years	Months	Days	If less than one day
74	---	---	-- hr. -- min.

9. Birthplace Oakland, Maryland (Town, county, and state)
10. Usual Occupation Salesman for
11. Industry or business Carroll A. Read

FATHER
12. Name Elbridge Gerry Hall
13. Birthplace Maryland

MOTHER
14. Maiden Name Amanda Bosley
15. Birthplace Maryland

16 (a) Informant Miss Lucy Bosley Hall
(b) Address 335 Yale Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/12/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Woodlawn
Location Woodlawn, Md.

18 (a) Funeral director H. W. Meads and Son
(b) Address 805 N. Calvert St.

DEC 11 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 9 1945, at 12:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-1- 1940, to 12-9- 1945, and that I last saw h[illegible] alive on 12-9 1945

Immediate cause of death	Duration
Arteriosclerotic heart disease	2 yrs
Due to Arteriosclerosis	5 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Howard F. W[illegible] M. D.
Address 1404 Garrison Blvd Date signed 12-10-45

VS 150

635003

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. 635003

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution:
University Hospital 181
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 845 Vine Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Laura Leak (Roberts)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: William Leak

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 19, 1899

8. AGE: Years 56 | Months 6 | Days 20 | If less than one day hr. min. 889

9. Birthplace Littleton N. C. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Doc Leak

13. Birthplace N.C

MOTHER 14. Maiden Name Ella

15. Birthplace N.C

16 (a) Informant Irvin Leak

(b) Address 119 Carver Rd. Turners Station

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof Dec. 12, '45 (month) (day) (year)

(c) Cemetery or crematory Rocky Mount, N. C.

Location

18 (a) Funeral director Mrs Katie R. Williams

(b) Address 322 N Schroeder St

(a) DEC 11 1945 (date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/8/1945, at 3:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/3/1945 to 12/8/1945, and that I last saw h. alive on 12/8/1945.

Immediate cause of death Diabetic Coma and Acidosis — Duration

Due to Diabetic Gangrene, L. foot.

Due to Diabetes mellitus

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 12/3/45

Major findings of operation: Gangrene of L. foot (amputation)

of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Will Anderson

Address Union Mem. Date signed 12/8/45 M. D.

Balto. 1, Md.

PHYSICIAN

Underline the cause to which death should be charged statistically.

635003

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓108

635003 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5813 Kildee Ct
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14yr
(e) Length of stay in Baltimore (yrs., mos., or days) 3 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County City
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5813 Kildee Ct
(If rural give location)
(e) Citizen of foreign country? Natio (Yes or No)
If yes, name country

3 (a) FULL NAME Michael Mansoore

3 (b) If veteran, name war: none
(c) Social Security Account No. 249-05-8351

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
m	c	Married

6 (b) Name of husband or wife: Mary [illegible]
6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) 12-12-1894

8. AGE: Years	Months	Days	If less than one day
50	11	28	none min.

9. Birthplace Bishopville, S.C (Town, county, and state)
10. Usual Occupation none
11. Industry or business Lather

FATHER
12. Name Dorschel Michael
13. Birthplace Bishopville, S.C

MOTHER
14. Maiden Name Peggy Sampson
15. Birthplace Bishopville, S.C

16 (a) Informant Mary Michael
(b) Address 5813 Kildee Ct

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/12/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Anne Arundel

18 (a) Funeral director Chas G. Cooper
(b) Address 512 N. Carrollton Ave.

DEC 11 1945 (Date rec'd by registrar)
(b) Huntingtown Anne Arundel, Md. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-1-45 19 at 6:34 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 19 45 to Dec 19 45 and that I last saw him alive on 12-8-45 19

Immediate cause of death (a) Pneumonia — Duration 1 mo

Due to (b) none

Due to (c)

Other Conditions none

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: none

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide none
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature [signature] M.D.
Address 101 Brookmont Blvd Date signed 12-4-45

63004

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓186a

Registration No. 63004

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1307 N. Milton ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WALTER BENJAMIN SPAMER

3 (b) If veteran, name war: no
3 (c) Social Security Account No. 214-16-5803

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Julia Spamer
6 (c) If alive, give age: 72 years

7. Birth date of deceased (mo., day, yr.): April 13, 1876

8. AGE: Years: 69 | Months: 7 | Days: 26 | If less than one day: hr. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual Occupation: Marine Machinist
11. Industry or business:

FATHER
12. Name: William Spamer
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden Name: Virginia Schalford
15. Birthplace: Baltimore, Maryland

16 (a) Informant: Mrs. Julia Spamer
(b) Address: 1307 N. Milton Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 12-11-45 (month) (day) (year)
(c) Cemetery or crematory: Baltimore Cemetery
Location: Baltimore, Maryland

18 (a) Funeral director: HENRY SANDER & SONS, I
(b) Address: NORTH AVE. & BROADWAY

19 (a) (Date rec'd by Registrar) Martin for Williams M.D. Registrar

DEC 13 1945

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 - 9 - 1945 at 2:40 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Shock
Fractured pelvis and ribs
Due to:
Other Conditions: Fractured clavicle. Contusions, bruises & lacerations
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-8- at 5 P.M.
(b) Where did injury occur? 1307 N. Milton ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? yes
(d) Means of injury: Heavy object struck, fell from window

23. Signature: Howard J. Weinberg M.D. Medical Examiner.
Date signed 12-9-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

~~635005~~

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 8 3a

Registered No. 635005

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Street
(c) Hospital or institution: Little Sisters of the Poor 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 59 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA BITTER HIRSCH

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	Widowed

6 (b) Name of husband or wife Adolf Hirsch
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Apr. 1. 1873

8. AGE: Years	Months	Days	If less than one day
72	8	9	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Tailoress
11. Industry or business

FATHER
12. Name Joseph Bitter
13. Birthplace Germany

MOTHER
14. Maiden Name Francesca Schaefer
15. Birthplace Germany

16 (a) Informant Records
(b) Address Little Sisters of the Poor

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 12. 1945 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore Md.

18 (a) Funeral director HENRY SANDER & SONS. INC.
(b) Address North Ave. & Broadway

19 (a) DEC 1 1945 Huntington Williams M.D. Registrar
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 10. 1945 at 12 15 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec-1- 1945, to Dec 10- 1945, and that I last saw her alive on Dec-9- 1946.

Immediate cause of death	Duration
Cerebral Hemorrhage	9 days
Due to Arterio-Sclerosis	5 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature G. Gill Hall M. D.
Address 1631 E. North Ave Date signed Dec 10-45

63005

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

557

Registered No. 63005

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Tenn. (b) County.....
(c) City or town Madisonville
(If outside city or town limits, write RURAL and give town)
(d) Street No.....
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Stelton Stiles

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, ~~widowed, or divorced~~.
Male	White	Married

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 25-1916

8. AGE: Years	Months	Days	If less than one day
29.	1	16	....hr. ....min.

9. Birthplace Tenn
(Town, county, and state)
10. Usual Occupation.....
11. Industry or business.....

FATHER
12. Name John B. Stiles
13. Birthplace Tenn

MOTHER
14. Maiden Name Lillian A. Stikely
15. Birthplace Tenn

16 (a) Informant.....
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 14/45 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Sunset
Location Madisonville Tenn

18 (a) Funeral director John O. Mitchell Son
(b) Address 1901 Eutaw Place

DEC 11 1945 (Date received by Registrar) (Signature) Hunter Jr for Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-10 1945, at 7:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-10 1945 to 12-10 1945 and that I last saw h.im alive on 12-10 1945.

Immediate cause of death	Duration
Respiratory failure	
Due to Carcinoma of Ethmoid sinus	
Due to Metastasis to brain	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence.....at.....M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?.....While at work?.....
(Specify type of place)
(e) Means of injury:.....
23. Signature William J. Dixon
Address Johns Hopkins Hospital Baltimore Md. Date signed 12/14/45

635007 635007

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No.

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N Caroline St
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 9 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1613 HARFORD AVE (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME WILLIAM A SCHLEIGH

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	717-07-8756

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	MARRIED

6 (b) Name of husband or wife Edythe M. Steinberg
6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) Nov 3 1883

8. AGE: Years	Months	Days	If less than one day
62	11	6	####### min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation CLERK
11. Industry or business Railroad

FATHER
12. Name John Schleigh
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Catherine Morgan
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Edythe Mae Schleigh
(b) Address 1613 Harford Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/12/45 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Ave., Balto; Co

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) DEC 11 1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 9 1945 at 2 39 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/8 1945 to 12/9 1945, and that I last saw h[illegible] alive on 12/9 1945

Immediate cause of death	Duration
Cardio Respiratory failure	1 day
due to Uremia	2 days
Due to Cerebral Hemorrhage	
Other Conditions Hypertension C-V Disease	undetermined

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury —

23. Signature Lawrence W Mackie M. D.
Address St Joseph's Hosp Date signed Dec 9 1945

VS 150 Huntington Williams, M.D. X

63608

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

63608 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 315 N. Mount
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Mc Donald

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-01-8723

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Anna Margaret Mc Donald

6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) June 8, 1891

8. AGE: Years	Months	Days	If less than one day
54 Sy	6	1	hr. min.

9. Birthplace Belto, Md.
(Town, county, and state)

10. Usual Occupation Steamfitter

11. Industry or business Steamfitters Local 486

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Ellen Dunn
15. Birthplace Ireland

16 (a) Informant Andrew John Mc Donald
(b) Address 315 N. Monastery Ave.

17 (a) Burial (b) Date thereof 11-13-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Cross Cem.
Location Annapolis Blvd.

18 (a) Funeral director Chas F. Dill
(b) Address 521 E. Fort Ave.

(a) (b)
(Date rec'd by Registrar) Registrar

DEC 11 1945

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 9, 1945, at 9:45 A. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute Congestive Cardiac Failure

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mullen M.D.
Medical Examiner.

Date signed 12-10-45

G35009

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G35009 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1811. Stiles St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 - V
(e) Length of stay in Baltimore (yrs., mos., or days) 38.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1011. Stiles St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Alexander DeSanctis

3 (b) If veteran, name war: First World.
3 (c) Social Security Account No. 243-00-8452

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife: Mary DeSanctis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1 1893

8. AGE: Years	Months	Days	If less than one day
52.	6	7	hr. min.

9. Birthplace Italy (Town, county and state)
10. Usual Occupation Tailor
11. Industry or business

FATHER 12. Name Anthony DeSanctis
13. Birthplace Italy

MOTHER 14. Maiden Name Maretta Tritta
15. Birthplace Italy

16 (a) Informant Mary DeSanctis
(b) Address 1011. Stiles St.

17 (a) Burial (b) Date thereof Dec 9 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Wendell Heppel
(b) Address 1215 Eutaw Place

19 (a) (Date rec'd by registrar) Williams, M.D. Registrar
DEC 11 1945

VS-350

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/7/45, at 8 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 4 1945 to Dec 7 1945, and that I last saw h[illegible] alive on Dec 6 1945.

Immediate cause of death	Duration
Pulmonary Oedema	24 hrs
Due to Chronic myocarditis	2 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature H. J. Jenkins M. D.
Address 100 N. Eutaw St. Date signed 12/9/45

X

635010

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

63 C

Registered No. 635010

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 117 S. Loudon Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) [illegible]

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Balto (b) County

(c) City or town Md

(If outside city or town limits, write RURAL and give town)

(d) Street No. 117 S. Loudon Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) **FULL NAME** Linda A Jackson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Infant

6 (b) Name of husband or wife: —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 16th 1945

8. AGE: Years | Months: 4 | Days: 25 | If less than one day: hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER

12. Name Wayne Jackson

13. Birthplace Md

MOTHER

14. Maiden Name Jane Barple

15. Birthplace Md

16 (a) Informant Mr. Wayne Jackson

(b) Address 117 S. Loudon Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 12th 1945 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Fredrick Road

18 (a) Funeral director Leo G. Leech

(b) Address 1701-03 N. Patterson Park Ave

(c) (Date received by registrar) (b) Huntington Williams M.D. (Signature of registrar)

DEC 11 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 10th 1945, at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1945 to Dec 10 1945 and that I last saw her alive on Dec 7 1945

Immediate cause of death: Acute lung-Tuberculosis — Duration: 3 days

Due to

Due to

Other Conditions Colitis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature J. V. Collins M. D.

Address 3821 Fred Ave Date signed 12/10/45

X

G35011 G35011

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 616 W. Lafayett ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 25 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town.)
(d) Street No. 616 W Lafayett ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alexander Branch

3 (b) If veteran, name war —

3 (c) Social Security Account No. 216-09-5760

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C.	married

6 (b) Name of husband or wife Willie Mae Branch
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years	Months	Days	If less than one day
60			hr. min.

9. Birthplace Va (Town, county, and state)
10. Usual Occupation Porter
11. Industry or business

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Harvey Cooper
(b) Address 1805 Brunt St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-13-45 (month) (day) (year)
(c) Cemetery or crematory Blackstone, Va
Location Va

18 (a) Funeral director George G. Kelson
(b) Address 1303 Presstman St

19 (a) DEC 1 1945 (Date received by Registrar) (b) Huntington Williams, Md Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 8 1945 5:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 3 1945 to Dec 8 1945 and that I last saw her alive on Dec 8 1945.

Immediate cause of death	Duration
Apoplexy	
Due to Hypertention	
Due to Cerebral Hemorrhage	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 703 W Lafayette ave Date signed 12-9-45

X

AB-97721 G35012

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G35012

Registered No. 1248

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2109 E. McElderry St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Bennett

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-14-1965

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 6- 1873

8. AGE: Years	Months	Days	If less than one day
72	11	4	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Bennett (D)
13. Birthplace Md.

MOTHER
14. Maiden Name ? (D)
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals (Records)
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 13th. 45 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet.
Location Frederick Ave.

18 (a) Funeral director Geo. M Fink & Son.
(b) Address 811. N. Wolfe St.

19 (a) DEC 11 1945 (b) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 10- 1945, at 12.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-6- 1945 to 12-10- 1945, and that I last saw h im alive on 12-10 1945.

Immediate cause of death: Pneumonia — Duration: ?

Due to: Cirrhosis — Duration: ?

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Margaret M. Davis M. D.
Address 4940 Eastern ave Date signed 12-14-45

X

635013

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1222

635013 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Josephine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County Baltimore
(c) City or town Hyde
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Lulu E Guyton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 16-1881

8. AGE: Years 64 | Months 0 | Days 24 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation House work

11. Industry or business

FATHER 12. Name Isiah Guyton
13. Birthplace Md.

MOTHER 14. Maiden Name Clara L. Moore
15. Birthplace Md.

16 (a) Informant Mrs. Cora Corbin
(b) Address Hyde Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 13-45 (month) (day) (year)
(c) Cemetery or crematory Quinn Chapel
Location Wilna Md.

18 (a) Funeral director Clarence E. Arthur
(b) Address Fork Md.

19 (a) DEC 1 1945 (Date rec'd by registrar) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-10 1945, at 9 15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-26 1945 to 12-10 1945 and that I last saw h[illegible] alive on 12-10 1945

Immediate cause of death Cardio respiratory failure — Duration

Due to Pulmonary Congestion

Due to Uremia

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 11-25-43
Major findings of operation: Intestinal obstruction
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Eugene L Peden M. D.
Address 1400 Eutaw Pl. Date signed 12-13-45

VS 150

Dr. Green
3009 Evergreen Ave.

G3:014

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G3:014
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3502 Hmailton Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3502 Hamilton Avenue-14-
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Lee Shanklin

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 27, 1865

8. AGE: Years	Months	Days	If less than one day
80	5	14	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name John W. Shanklin
13. Birthplace Md.

MOTHER
14. Maiden Name Margaret E. Cromwell
15. Birthplace Md.

16 (a) Informant Mr. John S.R.Shanklin
(b) Address 3502 Hamilton Avenue-14-

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-12-45 (month) (day) (year)
(c) Cemetery or crematory Prospect Hill
Location Towson, Md.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road-14-

19 (a) (Date rec'd by registrar) Huntington Williams M.D.

DEC 11 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH December 10, 1945, at 4:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1945 to Dec 10 1945, and that I last saw h alive on Dec 8 1945.

Immediate cause of death
Acute Cardiac Dilatation
Due to
Due to
Other Conditions Chronic Hypertension Arteriosclerosis
(Include pregnancy within 3 months of death)

Duration
Dec 10 1945
a minute
17 Years

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Morris B. Green M. D.
Address 3009 Evergreen Ave Date signed 12/11/45
Baltimore 14 Maryland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

63501.5

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1310

63501.5

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 814 N. Eden St

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto.

(If outside city or town limits write RURAL and give town)

(d) Street No. 814 N. Eden St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Emma Murray

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Charles Murray

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 2, 1850

8. AGE: Years 95 | Months 3 | Days 6 | If less than one day hr. min.

9. Birthplace White - Hall Md

(town, county, and state)

10. Usual Occupation At - Home

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden Name Unknown

15. Birthplace

16 (a) Informant Dorothy Lingle

(b) Address 814 N. Eden St

17 (a) Burial (b) Date thereof Dec. 12 1945

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location

18 (a) Funeral director Robert L. Grubb

(b) Address 864 N. Caroline St

19 (a) DEC 11 1945 (b) Huntington Williams, M.D. Registrar

(Date received by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 8 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 6 1945 to Dec 8 1945 and that I last saw h[er] alive on Dec 5 1945

Immediate cause of death	Duration
Uremia	
Due to Hypertension and Kidney failure	1 year
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Emmett R. Julian

Address 454 E. 23rd Date signed 12/9/45

X 18

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

63016

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 132

63016 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11hrs
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County KENT
(c) City or town Chestertown, Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 302 College Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME DR. William Richmond

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 29, 1886

8. AGE: Years 59 | Months 3 | Days 11 1/2 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation DOCTOR

11. Industry or business

FATHER 12. Name unknown
13. Birthplace

MOTHER 14. Maiden Name unknown
15. Birthplace

16 (a) Informant HOSPITAL RECORD
(b) Address BALTIMORE, MD

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof DEC 14 1945 (month) (day) (year)
(c) Cemetery or crematory COLEMAN
Location KENT COUNTY Md.

18 (a) Funeral director J WILLIS WELLS
(b) Address CHESTERTOWN, MD

DEC 11 1945 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 10 1945 at 10 50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 10 1945 to Dec 10 1945 and that I last saw him alive on Dec 8 1945

Immediate cause of death Uremia — Duration two days

Due to Glomerulonephritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.

Address [illegible] Date signed Dec 11 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35017 BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH G3501[illegible] Registered No. 467

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1000 Eaton Avenue
(c) Hospital or institution: Jenkins Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ Mos
(e) Length of stay in Baltimore (yrs., mos., or days) 7½ mos

2. USUAL RESIDENCE OF DECEASED:
(a) State ..... (b) County .....
(c) City or town Washington, D C
(If outside city or town limits, write RURAL and give town)
(d) Street No. 24 - 9th St N E
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Patrick Joseph Hennigan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Sarah Keenan

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 17, 1884

8. AGE: Years 61 | Months 8 | Days 22 | If less than one day ..... hr. ..... min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation Steam Engineer

11. Industry or business

FATHER
12. Name Thomas Hennigan
13. Birthplace Ireland

MOTHER
14. Maiden Name Catherine Conway
15. Birthplace Ireland

16 (a) Informant Mrs. Katherine Shank
(b) Address 1729 - Q St, N. W., Washington D C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-12-45 (month) (day) (year)

(c) Cemetery or crematory HOLY REDEEMER
Location Baltimore, Md.

18 (a) Funeral director WILLIAM COOK, ENG.
(b) Address 1217 ST. PAUL ST. Huntington Ave Williams, Md

(a) DAE (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 9 1945, at 12 35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 4 1945 to Dec 9 1945, and that I last saw h[illegible] alive on Dec 9 1945.

Immediate cause of death	Duration
Resp. Failure	
Due to Malnutrition & Cachexia	
Due to Carcinoma of Rectum & extensive metastases	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 12/7/45

Major findings of operation: Confirmed Carcinoma of Rectum & extensive metastases

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M. D.
Address [illegible] Date signed 12/9/45

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

635018

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D Registered No. 635018

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 116 S. Durham St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 65 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 116 S. Durham St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Josephine Konarski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1865

8. AGE: Years	Months	Days	If less than one day
80			hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Joseph Prusinlewski
13. Birthplace Poland

MOTHER
14. Maiden Name unknown
15. Birthplace Poland

16 (a) Informant Stanislaus Konarski
(b) Address Box 9 Ruth ave. Edgemere

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-12-45 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem
Location Balto. County

18 (a) Funeral director John M. Weber
(b) Address 401 S. Chester Street

19 (a) DEC 11 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 9 1945, at 8 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1945, to Dec 9 1945, and that I last saw h[illegible] alive on Dec 9 1945.

Immediate cause of death	Duration
Coronary Occlusion	Dec 1945
Due to	
Chr Myocarditis	12/1945
Other Conditions Generalized Arteriosclerosis	1940

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William J. Daniel M. D.
Address 804 Kenwood Ave Date signed Dec 10 1945

X

G35019 G35019

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 166

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Del. (b) County
(c) City or town Newark (If outside city or town limits, write RURAL and name town)
(d) Street No. 82 E Park Pl (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME David Truitt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/25/45

8. AGE: Years	Months	Days	If less than one day
	1½	15	hr. min.

9. Birthplace Newark Del (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Fletcher Truitt
13. Birthplace Maryland

MOTHER
14. Maiden Name Katherine Fell
15. Birthplace Penna

16 (a) Informant Katherine Fell
(b) Address Newark - Penna

17 (a) Removal (b) Date thereof 12-11-45 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory KIMBELSVILLE
Location PENN

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address [illegible] Penna. West Balto. MD

19 (a) 11 1945 (by registrar) (b) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/10 1945, at 9:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/5 1945 to 12/10 1945, and that I last saw him alive on 12/10 1945.

Immediate cause of death Coeliac Syndrome

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Collis M. Dennis
Address Kennedy Hospital Date signed 12/11/45 (M. D.)

63502 63502

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30 D

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Josephs Hospital 16 DOA
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1114 N. Stricker (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Coleman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1906

8. AGE: Years 39 | Months | Days | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Penn R R.

FATHER 12. Name William J. Coleman

13. Birthplace Md

MOTHER 14. Maiden Name Carrie B. Goldsborough

15. Birthplace Md

16 (a) Informant Genevieve Coleman

(b) Address 429 E 12th St Wilmington

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-12-45 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location A. A. 40

18 (a) Funeral director Rayner Sanders

(b) Address 1412 E. Preston St

19 (a) (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 8 - 1945, at 1.15 A.M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Ruptured Aortic Aneurysm

Due to

Other Conditions Hemoperiocardium

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Howard J. Mussers M.D. (Medical Examiner.)

Date signed 12-8-45

X

G35021

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92D

Registered No. G35021

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 721 W. Fayette St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimor
(If outside city or town limits, write RURAL and give town)
(d) Street No. 721 W. Fayette St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William L. Armstrong

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Married

6 (b) Name of husband or wife Dorothy Armiger
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 13, 1916

8. AGE: Years	Months	Days	If less than one day
29	1	24	hr. min.

9. Birthplace Baltimor, Md.
(Town, county, and state)
10. Usual Occupation Auto Mechanic
11. Industry or business Purity Creamery

FATHER
12. Name William A. Armstrong
13. Birthplace Maryland

MOTHER
14. Maiden Name Laura Arndorff
15. Birthplace Virginia

16 (a) Informant Laura E. Armstrong
(b) Address 721 W. Fayette St

17 (a) Burial (b) Date thereof 12/12/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location 2930 Frederick Road

18 (a) Funeral director Harry H. Wittle
(b) Address 4101 Edmondson Ave

19 DEC 12 1945 (b) [illegible] Williams, M.D.
(Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 9 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1945 to Dec 9 1945 and that I last saw h[illegible] alive on Dec 9 1945

Immediate cause of death	Duration
Acute Cardiac Dilatation	2 days
Due to	
Due to Fibrillar heart disease	?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry Stevenson M. D.
Address 26 D 7 Madison Ave Date signed Dec 10, 45

VS 150

X

635022

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. 635022

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1959 W. Lexington St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 d
(e) Length of stay in Baltimore (yrs., mos., or days) 5 0 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1959 W. Lexington St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary F. Foster

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	Married

6 (b) Name of husband or wife Jacob N.
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 1, 1872

8. AGE: Years	Months	Days	If less than one day
73	3	9	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name William H. Tracey
13. Birthplace Maryland

MOTHER
14. Maiden Name Annie E. Mofford
15. Birthplace Maryland

16 (a) Informant Mr. Jacob Foster
(b) Address 1959 W. Lexington St

17 (a) Burial (b) Date thereof 12-13-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3801 Frederick Rd

18 (a) Funeral director Harry H. Wilkes
(b) Address 4101 E. Monument Ave.

19 DEC 12 1945 (b) Huntingtown Williamsport MD
(Date rec'd by registrar) (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 10 1945 at 2.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/2 1945 to 12/10 1945
and that I last saw h alive on 12/10 1945

Immediate cause of death	Duration
Hemorrhage	1 day
Due to Malignant Colon	6 Mos
Due to	
Other Conditions Diabetes Mellitus	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Samuel K. Graham M.D.
Address 1111 Mercantile Bldg Date signed 12/14/45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

635063

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 635063

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3613 Edmondson ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3613 Edmondson ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie Hammer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Harry M. Hammer
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Mch. 19, 1863
8. AGE: Years 82 | Months 8 | Days 20 | If less than one day hr. min.
9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation H.W.
11. Industry or business

FATHER
12. Name John Foetler
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Stone
15. Birthplace Germany

16 (a) Informant Mrs. Jos. E Ebert
(b) Address 3613 Edmondson ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/12/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location 3801 Frederick Rd.

18 (a) Funeral director Harry H. Tuttle
(b) Address 4101 E Edmondson ave

19 (a) DEC 12 1945 (Date rec'd by registrar) (b) Huntington Williamsburg

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/9/45 19 at 9P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1942 to Dec 1945, and that I last saw her alive on 12/9 1945

Immediate cause of death	Duration
Edema of lungs	2 days
Due to Cl. myocarditis	4 yrs
Due to Arterio sclerosis	10 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo E. Wells M. D.
Address 4100 Edmondson Ave Date signed 12/10/45

VS 150

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

63504

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122a

Registered No. 63504

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (~~yrs., mos., or days~~) 32 ~~64~~
(e) Length of stay in Baltimore (~~yrs., mos., or days~~) 64

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 9 E. Becher St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph M. Langhirt

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-01-2941

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of ~~husband~~ or wife Lottie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 29 1879

8. AGE: Years 66 | Months 5 | Days 13 | If less than one day 12 hr. min.

9. Birthplace Conn. (Town, county, and state)

10. Usual Occupation Printer

11. Industry or business Lutz Printing Co

FATHER 12. Name Andrew J.

13. Birthplace Germany

MOTHER 14. Maiden Name Margaret Weigand

15. Birthplace Germany

16 (a) Informant Mrs. Lottie Langhirt

(b) Address 9 E Oliver Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/14/45 (month) (day) (year)

(c) Cemetery or crematory Parkwood

Location Harford Rd

18 (a) Funeral director Geo. H. Leuthardt

(b) Address 5 N. Howard St

DEC 12 1945 (Date rec'd by registrar)

(b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-11 1945, at 3 ~~46~~ P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-10 1945 to 12-11 1945 and that I last saw h~~is~~er alive on 12-11 1945

Immediate cause of death Cyanosis due to Hemorrhage

	Duration
Due to Hypostatic pneumonia and Bronchitis	
Due to CVD Arteriosclerotic Bilat. inguinal hernia	
Other Conditions Surgical Shock	

(Include pregnancy within 3 months of death)

Date of operation 11-28-45

Major findings of operation: Bilateral inguinal Hernia

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Frank W. Whitley M.D.
Address Church Home Hosp. Date signed 12-8-45

VS 180

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

635025

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 635025

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4801 Cordelia Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4801 Cordelia Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Francis M. Slack

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Ida S. Slack

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 16 1866

8. AGE: Years	Months	Days	If less than one day
79	1	24	hr. min.

9. Birthplace Balto. Co. Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Cigar Manufacturer

FATHER
12. Name John M. Slack
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Martha Broome
15. Birthplace Balto. Md.

16 (a) Informant John F. Slack
(b) Address 4801 Cordelia Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/12/45 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Balto. Co. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) Dec 12 1945 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 10th 1945, at 7 15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 17 1945, to Dec 10 1945, and that I last saw him alive on Dec 8 1945.

Immediate cause of death	Duration
Coronary Thrombosis	
Due to Arteriosclerosis	3 y
Due to Myocarditis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Emanuel Klein M. D.
Address 3611 Pimlico Rd Date signed 12-11-45

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

635026

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1251 Registered No. 635026

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Edmondson Grove Sta.
(c) Hospital or institution: University Hospital 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 302 S. Bruce St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SEALS, EUGENE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 30th 1937

8. AGE: Years	Months	Days	If less than one day
8	4	11	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Student

11. Industry or business Public School

FATHER
12. Name Charles M. Seals
13. Birthplace Roseville Ill.

MOTHER
14. Maiden Name Lillie Willard
15. Birthplace Foxville Md.

16 (a) Informant Chas. M. Seals
(b) Address 302 S. Bruce St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/14/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) DEC 13 1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/11 19 45; at 10 40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/9 19 45 to 12/11 19 45, and that I last saw him alive on 12/11 19 45.

Immediate cause of death Hemorrhagic Anemia — Cause Undetermined — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation?

of autopsy: Acute Anemia - Small

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John M. Dennis M. D.
Address University Hospital Date signed 12/11/45

118

635037

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. 635037

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2816 Riggs Ave.
(c) Hospital or institution: 16

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 53 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ---
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2816 Riggs Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Burton Workman

3 (b) If veteran, name war ---

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Wht.	Widowed

6 (b) Name of husband or wife Catherine F.W

6 (c) If alive, give address Orkney

7. Birth date of deceased (mo., day, yr.) Nov. 8, 1867

8. AGE: Years	Months	Days	If less than one day
78	1	3	....hr. ....min.

9. Birthplace Milford Del.
(Town, county, and state)
10. Usual Occupation Retired Clerk
11. Industry or business B. & O. R.R.

FATHER
12. Name Joshua J. Workman
13. Birthplace Del.

MOTHER
14. Maiden Name Julia Jones
15. Birthplace Unknown

16 (a) Informant Orian C. Workman
(b) Address 2816 Riggs Ave.

17 (a) Burial (b) Date thereof Dec. 14, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Union
Location Georgetown Del.

18 (a) Funeral director Robert S. Little
(b) Address 2700 Edmondson Ave.

DEC 12 1945 (b) Huntington for Hillcrest
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 11 19 45 at 6 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 7 19 45 to 19 ....; and that I last saw h.. alive on Dec 8 19 45.

Immediate cause of death (a) Cancer — Duration

Due to (b) Intestinal Obstruction

Due to (c)

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter A Cox M. D.

Address 917 Linden Ave Date signed 12/11/45

VS 150

X

63508

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

63508 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State North Carolina County
(c) City or town Charlotte
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FORREST WEBB

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1861

8. AGE: Years 44 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location University Medical School DEC 11 1945

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) DEC 12 1945 (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 4 1945, at 1058 M

21. I certify that I took charge of the remains described above, held an Inspection on Autopsy, Inspection or Inquiry and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Lobar Pneumonia

Due to

Other Conditions Chronic Alcoholism
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature John R. Davis M.D.
Medical Examiner.

Date signed 12/6/45

5135

63509

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

63039

Registered No. 1208

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 D: 0
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 617 S Bunton St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years 65 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School

18 (a) Funeral director
(b) Address

19 DEC 12 1945 (Date rec'd by registrar) (b) Registrar

DEC 11 1945
Commissioner of Health

MEDICAL CERTIFICATION

20. DATE OF DEATH November 30, 1945, at 7:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Generalized peritonitis

Due to Ulcerative colitis

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. Frantzen M.D.
Medical Examiner.
Date signed 12-1-45

VS 151

5134

63030 Mueller Faith Female X ✓ 63030

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D. O. A.
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Georgia (b) County .....
(c) City or town Savannah
(If outside city or town limits, write RURAL and give town)
(d) Street No. .....
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME M. C. Harris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife .....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1910

8. AGE: Years 35 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace ..... (Town, county, and state)

10. Usual Occupation .....

11. Industry or business .....

FATHER
12. Name .....
13. Birthplace .....

MOTHER
14. Maiden Name .....
15. Birthplace .....

16 (a) Informant .....
(b) Address .....

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/21/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location ~~University Medical School~~ DEC 11 1945
18 (a) Funeral director Mrs. Geo. H. Holland
(b) Address 1631 Druid Hill Ave.
19 (a) DEC 12 1945 (Date rec'd by registrar) (b) ..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 1, 19 45 at 1 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Tuberculous Caseous Pneumonia, bilateral.

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury .....

23. Signature Benedict Skotarski M.D.
Medical Examiner.
Date signed December 2, 1945.

VS 151

3133 3133 X

63051

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 63051

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Md.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3020 Linewood Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Etta Mae Huffman

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-03-5309

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Paul N. Huffman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 12, 1911

8. AGE: Years 34 | Months 2 | Days 27 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation Secretary

11. Industry or business Bendix Prize

FATHER 12. Name Unknown

13. Birthplace "

MOTHER 14. Maiden Name "

15. Birthplace "

16 (a) Informant Paul N. Huffman

(b) Address 3020 Linewood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-12-45 (month) (day) (year)

(c) Cemetery or crematory Parkwood

Location Taylor Ave.

18 (a) Funeral director John F. Denny, Inc.

(b) Address 915 Light St.

DEC 12 1945 (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 9, 1945, at 3:10 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary thrombosis
Hemorrhage infarct of
DUE TO left ventricle

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury ..... at ..... M.

(b) Where did injury occur? .....

(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....

(d) Means of injury .....

23. Signature Benedict Whitelee M.D.
Medical Examiner.

Date signed December 10, 1945.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

63502 — BALTIMORE CITY HEALTH DEPARTMENT — 63502 Registered No.

CERTIFICATE OF DEATH

937

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3605 Hillsdal Road
(c) Hospital or institution:

28

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State md. (b) County ba
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3605 Hillsdal
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ESTELLE A SNYDER

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	Widgle

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feby. 8, 1871

8. AGE: Years	Months	Days	If less than one day
74	10	4	hr. min.

9. Birthplace Balto.
(Town, county, and state)
10. Usual Occupation nothing
11. Industry or business

MOTHER | FATHER

12. Name John H. Snyder
13. Birthplace Balto.
14. Maiden Name Agnes Kerr
15. Birthplace Balto.

16 (a) Informant Mrs. WM. F. HUNTER
(b) Address 1506 Shadyside road

17 (a) burial (Burial, cremation, or removal) (b) Date thereof Dec 12 1945 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Green Mt. Ave. & North Ave.

18 (a) Funeral director John O. Mitchell Sons
(b) Address 1900 Eutaw Place

DEC 12 1945 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-9- 1945; at 8 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-1- 1945 to 12-9 1945 and that I last saw h[illegible] alive on 12-9- 1945

Immediate cause of death — Duration

Cardiovascular disease — 2 y-
Due to Acute cardiac dilatation — 2 days
Due to Arterio Sclerosis — —
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Howard W. Warren M. D.
Address 2604 Garrison Blvd. Date signed 12-11-45

X

G35053

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52B

Registered No. G35053

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2601 E Fayette St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town 2601 E Fayette St.
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Ruth A. Ingram

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Marvin Ingram
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 5 1905

8. AGE: Years 40 | Months 10 | Days 5 | If less than one day hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Charles A. Sutton
13. Birthplace Germany

MOTHER 14. Maiden Name Nellie C Sudiff
15. Birthplace Virginia

16 (a) Informant Marvin Ingram
(b) Address 2601 E Fayette St

17 (a) Burial (b) Date of rec'd 12-12-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Balto

18 (a) Funeral director Jos J Heyn & Son
(b) Address 3008 Pinkney Ave

DEC 12 1945 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 10 1945, at 4 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 6 1945, to Dec 10 1945, and that I last saw h er alive on Dec 10 1945

Immediate cause of death Carcinoma of Bladder — Duration 3-4 months

Due to

Due to

Other Conditions Metastases-Pelvic & Lumbar glands — 1 month
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jos J Gordon M.D.

Address 3400 Pinkney Ave Date signed Dec 11 1945

G35034

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 132

G35034 Registered No. 4747

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 931 Rutland Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 4
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 931 Rutland Ave
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James Adrian Pack

3 (b) If veteran, name war: No
3 (c) Social Security Account No. -

4. Sex: M
5. Color or race: Col
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: -
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 10 1925

8. AGE: Years 20 | Months 11 | Days 0 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation -
11. Industry or business -

FATHER
12. Name James E. Pack
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Marie Smith
15. Birthplace Baltimore Md

16 (a) Informant Beatrice Reed
(b) Address 931 Rutland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 15/45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location A. A. County Md

18 (a) Funeral director Mrs Roberts A. Elliott & Dtr
(b) Address 945 W. Caroline St.

DEC 12 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 10 1945 at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 25 1945 to Dec 9 1945 and that I last saw him alive on Dec 9 1945.

Immediate cause of death Pulmonary Tuberculosis — Duration

Due to Tuberculosis of Spine.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation -

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R B Lighteton Jr. M. D.
Address 501 Cherry Hill Rd Date signed 12/10/45

635035

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

635035 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Marion Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 600 E. Lafayette ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Max Sacks

3 (b) If veteran, name war	3 (c) Social Security Account No.
–	–

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Irene –
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1894

8. AGE: Years	Months	Days	If less than one day
51			hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Furniture Salesman
11. Industry or business

FATHER
12. Name Abraham –
13. Birthplace Russia

MOTHER
14. Maiden Name Regina –
15. Birthplace Russia

16 (a) Informant Allan J. Sacks
(b) Address 3100 Reed Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-12-45 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location Balto & Conkling Sts

18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E. Balto St.

19 DEC 12 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-10- 1945 at 12 00 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Wiesel M.D.
Medical Examiner.
Date signed 12-10-45

635056

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. 635056

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3407 Wood Brook Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 42 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3407 Wood Brook Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: NATHAN OSEROFF

3 (b) If veteran, name war: —

3 (c) Social Security Account No.: —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	WHITE	WIDOW

6 (b) Name of husband or wife: LENA
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 1885

8. AGE: Years	Months	Days	If less than one day
60			hr. min.

9. Birthplace: RUSSIA (Town, county, and state)
10. Usual Occupation: PLUMBER
11. Industry or business

FATHER
12. Name: NOT KNOWN
13. Birthplace: RUSSIA

MOTHER
14. Maiden Name: NOT KNOWN
15. Birthplace: RUSSIA

16 (a) Informant: MRS. SAM SCHWARTZ
(b) Address 3407 WOODBROOK AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12-12-45 (month) (day) (year)
(c) Cemetery or crematory AITZ CHAIM
Location WASH. BLVD

18 (a) Funeral director JACK LEWIS INC.
(b) Address 1439 E. BALTO. ST.

19 (a) DEC 12 1945 (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 - 10 - 1945, at 10:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1944 to Dec. 10 1945, and that I last saw him alive on Dec. 10 1945

Immediate cause of death	Duration
Pulmonary Embolism	
Due to Myocarditis	
Due to Bronchopneumonia	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: W. E. Needle M. D.
Address 2314 W. North Ave. Date signed 12/11/45

VS 150

63037

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. 63037

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rutland & Cypress
(c) Hospital or institution:
West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3956 Penhurst Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Harry Abramson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Anna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years 47 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Roumania
(Town, county, and state)

10. Usual Occupation Merchant

11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Roumania

MOTHER
14. Maiden Name Not Known
15. Birthplace Roumania

16 (a) Informant Hosp Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-12-45 (month) (day) (year)
(c) Cemetery or crematory Mount Montefiore
Location Wash. Rd.

18 (a) Funeral director Sank Lewis Inc
(b) Address 1439 E. Balto St

DEC 12 1945 (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 11 1945, at 6:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/9 1945, to 12/11 1945, and that I last saw h alive on 12/11 1945.

	Duration
Immediate cause of death Cerebral hemorrhage	
Due to Painful Congenital aneurysm of Circle of Willis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Theodore Baldwin M.D.
Address West Baltimore General Hospital Date signed 12/14/45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

635058

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 12 1a

635058 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3520 Hilton Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Yrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3520 Hilton Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Emma V. Becker

3 (b) If veteran, name war --

3 (c) Social Security Account No. none

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Charles Becker

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 23, 1853

8. AGE: Years 92 | Months 4 | Days 17 | If less than one day hr. min.

9. Birthplace Kentucky (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Harig
13. Birthplace Not Known

MOTHER
14. Maiden Name Not Known
15. Birthplace Not Known

16 (a) Informant Mrs. Katherine G. Smith
(b) Address 5507 Link Ave. Arbutus

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-12-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore, Md.

18 (a) Funeral director D. Howard Strong
(b) Address 3207 W. North Ave.,

19 (a) DEC 12 1945 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 10, 1945, at 4.00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1945 to Dec 10 1945, and that I last saw him alive on Dec 9 1945.

	Duration
Immediate cause of death: Bronchio Pneumonia	8 d.
Uraemia	5 d.
Due to Arterio Sclerosis Hypertension	10 y.
Due to Chronic Interstitial Nephritis	10 y.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E F A Stevens M. D.

Address 2818 Harford Rd Date signed 12-11-45

X

635039

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1318

635039 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2219 E.Fayette St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) b
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city limits write RURAL and give town)
(d) Street No. 2219 E.Fayette St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George L.Wittig

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower
6 (b) Name of husband or wife: Lillie M.Wittig
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Dec.20-1879
8. AGE: Years 65 Months 11 Days 21 If less than one day hr. min.
9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Splicer
11. Industry or business C&P Telphone Co.

FATHER
12. Name Jacob Wittig
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Not Known
15. Birthplace Not Known

16 (a) Informant Edna Wittig
(b) Address 2219 E.Fayette St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec.14/45 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem.
Location Eastern Ave.

18 (a) Funeral director John A.Miller
(b) Address 2334 Jefferson St.

19 (a) DEC 12 1945 (Date received by Registrar) (b) Huntington Williams MD

MEDICAL CERTIFICATION

20. DATE OF DEATH December 10 1945, at 5:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1935 to Dec 10 1945, and that I last saw h[illegible] alive on Dec 10 1945.

	Duration
Immediate cause of death: Acute Bronchopneumonia	5 days
Due to: Chron. Endo-myocarditis	17 yrs.
Due to:	
Other Conditions: Chronic Nephritis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank J. Ayd M. D.
Address 2005 E. Monument St Date signed 12/11/45

VS 150

X

63,0,0 JL - 97632

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 63,0,10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

REMAIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 608 Dolphin St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Kenneth Augustus Johnson

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Div.

6 (b) Name of husband or wife Iolia Belle
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 9, 1908

8. AGE: Years	Months	Days	If less than one day
37	2	0	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name William Johnson
13. Birthplace U. S. A.

MOTHER
14. Maiden Name Stella ?
15. Birthplace ?

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 12, 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore Md.

18 (a) Funeral director Thos. Geo. H. Stollard
(b) Address 1631 Druid Hill Ave.

(c) DEC 12 1945 Huntington Williams M.D. (Date received by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 9, 1908 1945, at 6:00 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1 1945, to Dec. 9 1945. and that I last saw him alive on Dec. 9 1945

Immediate cause of death	Duration
Uremia	7
Due to Chronic Glomerulonephritis	1
Due to	
Other Conditions Hypertension	7

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Margaret M. Davis M.D.
Address 4940 Eastern Ave. Date signed 12-M

MARET M. DAVIS, M.D. X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BLANK RESERVED FOR BINDING

G350:1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. G350:1

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1116 Ridgely St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1116 Ridgely St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna K. Moser

3 (b) If veteran, name war —
3 (c) Social Security Account No. —
4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife John Moser
(c) If alive, give age 81 years
7. Birth date of deceased (mo., day, yr.) May 24. 1866
8. AGE: Years 79 Months 8 Days 16 18 If less than one day hr. min.
9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name Conrad Fritz
13. Birthplace Germany.

MOTHER
14. Maiden Name Mary Heidlach
15. Birthplace Germany

16 (a) Informant Mamie Moser
(b) Address 1116 Ridgely St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 13-1945 (month) (day) (year)
(c) Cemetery or crematory Western
Location City
18 (a) Funeral director Mrs. Nora John W. Deufel Son
(b) Address 801 W. Fayette St.
19 (a) DEC 14 1945 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 11 1945 at 3 05 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from Dec 4 1945 to Dec 11th 1945 and that I last saw h. alive on Dec 11th 1945.

Immediate cause of death Heart Failure — Duration 1 week
Due to Arterio-sclerosis — 3 years
Due to Senility
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence [redacted]
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature J. E. Poulton
Address 390 Edgewood Blvd Date signed Dec 14 1945

VS 180

63502

CWK-10997

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. 6350

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 26-12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27- 0- 17-
(e) Length of stay in Baltimore (yrs., mos., or days) 44 Yrs. ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. No Home
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Schipakinski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 2-1856

8. AGE: Years	Months	Days	If less than one day
89	6	2	hr. min.

9. Birthplace Russia ?
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Henry Schipakinski
13. Birthplace Russia

MOTHER
14. Maiden Name Anna Guer
15. Birthplace Russia

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/12/45 (month) (day) (year)
(c) Cemetery or crematory Laurel Heights
Location Leppercorn Rd

18 (a) Funeral director Lakeside
(b) Address 319 Lighthouse

DEC 12 1945 (Date received by registrar) (b) Livingston Williams, MD Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 4 1945, at 2:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 26 1945, to Dec. 4 1945, and that I last saw h. im alive on Dec. 4 1945

Immediate cause of death Primary Carcinoma of liver — Duration ?

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: none

of autopsy: Carcinoma of liver

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature T. P. Jerrigan M. D.
Address Baltimore City Hosp. Date signed 12-10-45

X

6350-3

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

6350-3 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6722 Railway Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6722 Railway Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Isabelle R Nelson

3 (b) If veteran, name war No
3 (c) Social Security Account No. None

4. Sex F.
5. Color or race W.
6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 6 1861

8. AGE: Years 84 | Months 81 | Days 10 | If less than one day 5 hr. min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name George W. Nelson
13. Birthplace Nottingham Square N. J.

MOTHER
14. Maiden Name Elizabeth M.
15. Birthplace Balto.

16 (a) Informant Lillian Stanford
(b) Address 6722 Railway Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/13/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location E. end of North Ave.

18 (a) Funeral director M. W. E. Doppels Sons
(b) Address 140 Howard and Ann Sts.

DEC 12 1945 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 11 1945 at 10:35 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-10/45 to 12-11-1945 and that I last saw h alive on 19

Immediate cause of death: Myocardial Degeneration — Duration 3 hrs.
Due to
Due to
Other Conditions Coronary Stenosis 2 yrs
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. H. Herrmann M. D.
Address 710 E 33rd St Date signed 12/12/45

VS 150

6350:4

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

6350:4 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: CHURCH HOME AND HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County BALTIMORE
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1345 Homestead St.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME GERTRUDE KATHERINE REYMANN

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	SINGLE

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) [illegible]

8. AGE: Years	Months	Days	If less than one day: hr.	min.
22	8	11		

9. Birthplace BALTIMORE, Md
(Town, county, and state)
10. Usual Occupation TELEPHONE OPERATOR
11. Industry or business

FATHER
12. Name HILDEBERT W. REYMANN
13. Birthplace BALTIMORE Md

MOTHER
14. Maiden Name HELENA SMITH
15. Birthplace BALTIMORE

16 (a) Informant HILDEBERT GERTRUDE REYMANN
(b) Address 1345 Homestead AVE.

17 (a) Burial (b) Date thereof 12/15/1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd

18 (a) Funeral director Thomas J. Burke
(b) Address 3805 Harford Rd

12 12 1945 Hunting for Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 12, 1945; at 1 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 2 1945 to Dec 12 1945 and that I last saw her alive on Dec 12 1945

Immediate cause of death	Duration
ACUTE TUBERCULOSIS, POST OPERATIVE FOLLOWING	5 days
Due to A PNEUMONECTOMY RIGHT SIDE	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 12-8-45
Major findings of operation: Tuberculosis, Tuberculous Empyema, right side
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature O. W. Camponeschi, M.D.
Address Church Home & Hospital Date signed 12-12-45

VS 150

O.W. CAMPONESCHI, M.D. X

63:045

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. 63:045

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2734 Pennsylvania Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eileen Ann Antonio

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 22, 1931

8. AGE: Years	Months	Days	If less than one day
14	3	17	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Student
11. Industry or business

FATHER
12. Name Theodore Antonio
13. Birthplace Italy

MOTHER
14. Maiden Name Florence Magoon
15. Birthplace Ripley, N. Y.

16 (a) Informant Mr. Theodore Antonia
(b) Address 2734 Pennsylvania Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/14/45 (month) (day) (year)
(c) Cemetery or crematory Greek Orthodox Evangeli
Location Baltimore, Md.

18 (a) Funeral director Wm. J. Tickner & Sons, Inc.
(b) Address North & Pa. Aves., Balto.

DEC 12 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/9 1945, at 6P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/6 1945 to 12/9 1945, and that I last saw her alive on 12/9 1945.

Immediate cause of death	Duration
(a) cerebral edema	3 days
Due to extradural hematoma	4 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 12/5/45
Major findings of operation: extra dural hematoma
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accid
(b) Date of occurrence 12/5/45 at 11 A M
(c) Where did injury occur? Maryland Training School (City or town) Baltimore (County) Md.
(d) Did injury occur about home, on farm, industrial place, in public place? Training School While at work? no
(Specify type of place)
(e) Means of injury Struck by a Table
23. Signature John Daeuges M.D.
Address University Hosp. Date signed 12/9/45

Howard D. Westfall, M.D. X

63506

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

63506 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution: Maryland General 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 614 Waldwood Rdy.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dora M. Schneider

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Wm. H. Schneider
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 23, 1885

8. AGE: Years	Months	Days	If less than one day
60	9	18	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name John J. Kreiner
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Maggie A. Schneider
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Joseph Kreiner
(b) Address 401 Reisterstown Rd. Pikesville

17 (a) Burial (b) Date thereof 12/14/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem
Location Pikesville, Md.

18 (a) Funeral director Wm. J. Tickner & Sons, Inc.
(b) Address North & Pa. Ave. Baltimore

(Date received by local registrar) DEC 12 1945 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/11 1945, at 4:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/9 1945, to 12/11 1945, and that I last saw her alive on 12/10 1945.

Immediate cause of death	Duration
Generalized Metastasis	
Due to Carcinoma Breast	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Martin E. Strobel M. D.
Address Md. Med Hospital Date signed 12/14/45

63.0:7

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

June 83a

63.0:7

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2243 N. Fulton Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 38 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2243 N. Fulton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Schuster

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Emma V.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 19, (1877)

8. AGE: Years	Months	Days	If less than one day
68	4	21	hr. min.

9. Birthplace Austria (Town, county, and state)
10. Usual Occupation M. D. Physcian
11. Industry or business

FATHER
12. Name George Schuster
13. Birthplace Austria

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs. George Schuster
(b) Address 2243 N. Fulton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 12 1945 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Parkville Md.

18 (a) Funeral director William J. Tickner & Sons
(b) Address North & Pennsylvania Aves.

DEC 12 1945 (Date rec'd by registrar)
(b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

P

20. DATE OF DEATH Dec. 10, 1945, at 12:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 7 1945 to Dec. 10 1945 and that I last saw h alive on Dec. 1 1945

Immediate cause of death Cerebral Apoplexy — Duration
Due to Arteriosclerosis.
Due to Bronchopneumonia
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature
Address 7314 - 22 North St. Date signed 12/11/45 M. D.

VS 130

X

63508

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 64

Registered No. 63508

PLEASE WRITE PLAINLY, with UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp. 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 705 Reservoir
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James D. Bavaro

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 30, 1945

8. AGE: Years	Months	Days	If less than one day
	3	10	hr. min.

9. Birthplace Hendersville N. C.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name James Bavaro
13. Birthplace Harrisburg, Pa.

MOTHER
14. Maiden Name Marie Lyda
15. Birthplace Hendersville N. C.

16 (a) Informant Mr. James Bavaro
(b) Address 705 Reservoir St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/13/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Wm. J. Tinkner & Sons Inc.
(b) Address North & Pa. Aves.

19 (a) DEC 12 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 10 1945; at 4 05 PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Status Thymico-lymphaticus

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Roland Lee Frahm M.D.
Medical Examiner.
Date signed Dec 11 1945

X

T 6350:9

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121

Registered No. 6350:9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner + Dureland Sts.
(c) Hospital or institution: West Baltimore General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 44 days
(e) Length of stay in Baltimore (yrs., mos., or days) 9 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 833 Abbott Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Trzcinski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife John Trzcinski
6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) Feby 29. 1906

8. AGE: Years	Months	Days	If less than one day
39	9	11	hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation

11. Industry or business At Home

FATHER
12. Name A C Brown
13. Birthplace Va

MOTHER
14. Maiden Name Susan Sydnor
15. Birthplace Va

16 (a) Informant John Trzcinski
(b) Address 833 Abbott Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 13 4 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem Co
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 200 E Lanvale St

19 (a) DEC 12 1945 (b) Thurlington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-10 1945, at 3:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-27 1945 to 12-10 1945, and that I last saw h.e.r alive on 12-10 1945

Immediate cause of death	Duration
Toxic Myocarditis	
Due to Generalized Sepsis	
Generalized Peritonitis	
Due to Ruptured Appendix	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 10-27-45

Major findings of operation: Ruptured Appendix - Generalized Peritonitis

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benjamin Berkowsky M.D.
Address W.B.G.H. Date signed 12/10/45

VS 150

63500 BALTIMORE CITY HEALTH DEPARTMENT 63500
CERTIFICATE OF DEATH 61

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Aves
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: Baltimore
(a) State Md (b) County Catonsville
(c) City or town Baltimore-28 (If outside city or town limits, write RURAL and give town)
(d) Street No. 105 S. Prospect Ave (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No) If yes, name country Italy

3 (a) FULL NAME Mrs Mary Dintino — Mary D'Intino
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Female 5. Color or race White 6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Pietro PIETRO
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) January 25 1881
8. AGE: Years 64 Months 10 Days 15 If less than one day hr. min.
9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business
FATHER 12. Name Antonio Poce
13. Birthplace Italy
MOTHER 14. Maiden Name Di Domenico Carmela
15. Birthplace Italy
16 (a) Informant Pietro D'Intino (Husband)
(b) Address 105 S. Prospect Ave (Catonsville Md
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 14/45 (month) (day) (year)
(c) Cemetery Holy Redeemer
Location Belair Rd. Baltimore Md.
18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Morley St.
19 (a) DEC 12 1945 (Date received by Registrar) (b) Huntington Woods Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/10 1945, at 11 PM
21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw h alive on 19

	Duration
Immediate cause of death Acute Respiratory Failure	
Due to Cerebral Hemorrhage	
Due to Hypertensive Cardio-Vascular Disease	
Other Conditions Diabetes Mellitus. (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Arthur T. Hall Jr. M. D.
Address St. Agnes Hosp. Date signed 12/10/45

VS 150

93D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

63504 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

63504 1 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 315 E. 27th St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 315 E. 27th St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Mae Fiumara

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	White	married

6 (b) Name of husband or wife Anthony Fiumara
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 13 1910

8. AGE: Years	Months	Days	If less than one day
35	10	28	hr. min.

9. Birthplace Womelsdorf Pa
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business home

FATHER
12. Name Samuel Spayd
13. Birthplace Womelsdorf Pa.

MOTHER
14. Maiden Name Emma Evans
15. Birthplace Womelsdorf Pa.

16 (a) Informant Anthony Fiumara (Husband)
(b) Address 315 E. 27th St.

17 (a) Burial (b) Date thereof Dec. 13 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory: Milbach
Location Stouchsburg Pa.

18 (a) Funeral director Frank Della Noce
(b) Address 52 N. Morley St.

19 (a) DEC 12 1945 (Date received by Registrar) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-11-45 19 at 6:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 13, 1944 to 12-11-1945 19, and that I last saw h e alive on 12-11-45 19

Immediate cause of death adeno carcinoma of cervix

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John Constantini, M.D.
M. D.
Address 34 E. Conkling St. Date signed 12-12-45

CONstantini X

635052

AB-97548

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √61

Registered No. 6350

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 71
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1216 N. BROADWAY (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Samuel Frazier

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Div.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 27- 1878

8. AGE: Years 67 | Months 11 | Days 13 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation HIGHWAY DEPT.

11. Industry or business CITY OF BALTIMORE

FATHER
12. Name Charles Frazier
13. Birthplace Md.

MOTHER
14. Maiden Name Mary E. Hines
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12/13/45 (month) (day) (year)
(c) Cemetery or crematory MORELAND MEM
Location TAYLOR AVE

18 (a) Funeral director CLARENCE F. HOFFMAN
(b) Address 1639 N. BROADWAY

19 (a) Embalmer (b) Registrar Huntington for Williams M.D.

DEC 12 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 10- 1945, at 4.10A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-28 1945 to 12-10- 1945 and that I last saw h. im alive on 12-10 1945

Immediate cause of death Coronary occlusion — Duration ?

Due to Atherosclerotic heart disease — Duration ?

Due to — Duration ?

Other Conditions Diabetes mellitus — Duration ?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Coronary occlusion & mural thrombus

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Marguerite A. Davis M. D.
Address 4940 Eastern ave. Date signed 12-11-45

93D

63503 — BALTIMORE CITY HEALTH DEPARTMENT — 63503

CERTIFICATE OF DEATH 83a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2309 Hunter St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2309 Hunter St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: ELIZABETH EARLES

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 26, 1882

8. AGE: Years	Months	Days	If less than one day
62	11	14	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Abraham Smallwood
13. Birthplace Md.

MOTHER
14. Maiden Name Clara Jenkins
15. Birthplace Md.

16 (a) Informant Mrs. Daniel Earles
(b) Address 403 East 24th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-13-45 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore Co., Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

DEC 12 1945 (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

P

20. DATE OF DEATH Dec. 10, 1945, at 5:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-8-45 19..., to 12-10-45 19..., and that I last saw h.. alive on 12-10-45 19...

Immediate cause of death	Duration
CEREBRAL Hemorrhage	2 days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Mabel Sims

Address 3 L E 23rd St Date signed 12-13-45 M. D.

35054

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 35054

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Herring Run & Harford Rd.
(c) Hospital or institution: Sydenham Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2326 Cambridge St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eugene (Fisher) Hohmann

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 28, 1940

8. AGE: Years: 5 | Months: - | Days: 14 | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Charles D. Fisher
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Hofmann
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Marie Fisher Hohmann
(b) Address 2326 Cambridge St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/14/45 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Govans Ridge Road

18 (a) Funeral director J. M. Sadowski & Son
(b) Address 1809 Eastern Ave

19 DEC 12 1945 (b) Hunting for Williamsport, Md.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 12 1945, at 4 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-3 1945 to 12-12 1945 and that I last saw him alive on 12-12 1945

Immediate cause of death	Duration
Diphtheritic Myocarditis	
Due to Pharyngeal Diphtheria	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: ✓

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Elsie Fijah Sprague M.D.
Address Sydenham Hosp. Date signed 12-12-45

G35055

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √181

Registered No. G35055

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution:
JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6d
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1902 Orland St.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME William H. Ashley Jr

3 (b) If veteran, name war.....
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife.....
6 (c) If alive, give age.....years

7. Birth date of deceased (mo., day, yr.) 9-13-40

8. AGE: Years 5 | Months 2 | Days 28 | If less than one day .....hr. .....min.

9. Birthplace Ky. (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name William Ashley
13. Birthplace Ky.

MOTHER
14. Maiden Name Nadie Osburne
15. Birthplace Ky

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 12/12/45 (month) (day) (year)
(c) Cemetery or crematory
Location Ashland (Kentucky)

18 (a) Funeral director Phillip Henry Dove
(b) Address 2024 Orleans St.

19 (a) DEC 12 1945 (Date received by Registrar) (b) Huntington, West Virginia

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 11 1945 at 2:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 10 1945 to Dec 11 1945 and that I last saw h[illegible] alive on Dec 11 1945

Immediate cause of death: 3rd degree burns — Duration: 24 hours

Due to.....

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operation:.....

of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 12/10/45 at 9:00 P.M.
(c) Where did injury occur? Balt (City or town) Md (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury: Clothes caught fire from [illegible]

23. Signature [illegible] M. D.
Address [illegible] Date signed Dec 11, 45

Approved: Robert Lee Grotten M.D.

G35056

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G35056

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway
(c) Hospital or institution: Church Home & Hospital

(d) Length of stay in hospital or inst. (yrs., ~~mos.~~, or days) 29
(e) Length of stay in Baltimore (yrs., mos., or days) ✓

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Church Hom & Hosp. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alice Washington

3 (b) If veteran, name war

3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, ~~married~~, widowed, or ~~divorced~~.
F	W	

6 (b) Name of husband or wife ✓
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
61 ?			hr. min.

9. Birthplace Ohio (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name
15. Birthplace "

16 (a) Informant Mrs. Edwin B. Niper
(b) Address 29 Farrington Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 14/45 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Greenmt + Oliver Sts.

18 (a) Funeral director Thos. O. Mitchell & Sons
(b) Address 1900 Eutaw Place

19 (a) DEC 12 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-11-1945, at 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-1-1945 to 12-11-1945 and that I last saw him alive on 12-5-1945.

Immediate cause of death Cerebral Vascular Accident?
Due to Arteriosclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Frank M. Shipley M. D.
Address Church Home & Hosp. Date signed 12-13-45

VS 150

G35057

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1248

Registered No. G35057

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address LOMBARD & GREEN STS.
(c) Hospital or institution: UNIVERSITY HOSP. 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 DAS.
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County BALTO.
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 312 N. PACA ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Frank E. Steinmintz

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.: NONE

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: DIVORCED

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 1890

8. AGE: Years 55 | Months 5 | Days | If less than one day hr. min.

9. Birthplace BALTIMORE MD. (Town, county, and state)

10. Usual Occupation BOARDING HOUSE KEEPER

11. Industry or business FOR SELF

FATHER
12. Name FREDERICK STEINMETZ
13. Birthplace GERMANY

MOTHER
14. Maiden Name ANNA CARTER
15. Birthplace GERMANY

16 (a) Informant ELIZABETH STEINMETZ (DAUGHTER)
(b) Address 746 S. DECKER AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof DEC. 13/45 (month) (day) (year)
(c) Cemetery or crematory OAK LAWN
Location EASTERN AVE. EXT.

18 (a) Funeral director Lilly & Zeiler inc.
(b) Address 403 S. WOLFE ST.

19 DEC 12 1945 (Date received by registrar) Registrar for Williams

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/10 1945 at 9:35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/8 1945, to 12/10 1945, and that I last saw h.im. alive on 12/10 1945.

Immediate cause of death: Rupture esophageal varices

Due to: Early cirrhosis of liver

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation: several ruptured veins in esophagus. Very large

of autopsy: fatty liver

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard H. Skinner, Jr. M.D.

Address University Hosp. Date signed 12/10/45

G35058

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Register G35058

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3356 Wilkens Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3356 Wilkens Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Anna M. Moon

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-03-2120

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 11, 1886

8. AGE: Years 59 | Months 1 | Days 29 | If less than one day hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation Saleslady

11. Industry or business Stewart & Co Dept. Store

FATHER
12. Name Harry O. Moon
13. Birthplace Md.

MOTHER
14. Maiden Name Christiana Schaener
15. Birthplace Md.

16 (a) Informant Richard O. Moon (Brother)
(b) Address 2710 Georgetown Rd, Balto. 30, Md.

17 (a) Burial (b) Date thereof Dec. 13, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western Cemetery
Location Baltimore, Md.

18 (a) Funeral director P. Howard Evans
(b) Address 1400 S. Charles St., Balto. 30, Md.

19 (a) DEC 12 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 10, 1945, at 7:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1945 to Dec 10 1945, and that I last saw h[illegible] alive on Dec 10 1945.

Immediate cause of death: Coronary Thrombosis
Due to: Cardio-Vascular Disease
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)

Duration: 1 day / 2 Months

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Eliot W. Coleman
Address 3432 Juniata Ave Date signed 12/11/45

G35059

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 94a

Registered No. G35059

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1 West Biddle
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5 St John Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DAVID FULTON

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Virginia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 2, 1883

8. AGE: Years 62 | Months 4 | Days 19 | If less than one day ____hr. ____min.

9. Birthplace Gainsville Ala
(Town, county, and state)

10. Usual Occupation Inspector

11. Industry or business Mfg Co

FATHER
12. Name Leonard A Fulton
13. Birthplace Ala

MOTHER
14. Maiden Name Eugenia Russell
15. Birthplace Miss

16 (a) Informant Virginia Fulton
(b) Address 5 St Johns Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/13/45 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge
Location Catonsville Md

18 (a) Funeral director Wilson Colston
(b) Address 1217 E Cold St

19 DEC 12 1945 (Date rec'd by registrar) Hunter Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/11/45 19____, at 6 P. M.

21. I certify that I took charge of the remains described above, held an Inspection Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to ____death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ____ at ____ M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R Davis M.D.
Medical Examiner.
Date signed 12/11/45

VS 151

G35060

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. G35060

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rukeland & Lanyon
(c) Hospital or institution:
West Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 573 Bruce St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ethel M. Day

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife: Chester
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 6, 1900

8. AGE: Years	Months	Days	If less than one day
45	4	6	hr. min.

9. Birthplace Mt Savage Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Grant Brant
13. Birthplace Unknown

MOTHER
14. Maiden Name Flat (Unknown)
15. Birthplace Md

16 (a) Informant Chester Day
(b) Address 573 Bruce St

17 (a) Cremated (b) Date thereof 12/12/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Savage
Location Mt Savage Md

18 (a) Funeral director Wilson Funeral Home
(b) Address 1217 E Fort Ave

19 (a) DEC 1945 (b) [illegible] Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION 45

20. DATE OF DEATH Dec. 11 1945, at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-8 1945 to 12-11 1945, and that I last saw her alive on 12-11 1945.

Immediate cause of death	Duration
Cerebral hemorrhage	
Due to Hypertensive Cardiovascular disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address West Baltimore General Hosp. Date signed 12-12-45

X

G35061

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G35061 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dr. Kolmer & Raymar Ave.
(c) Hospital or institution: W. Balto. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 10 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 136 S. Fulton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Meeker #2

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-28-45

8. AGE: Years	Months	Days	If less than one day
		10	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Frank Giza
13. Birthplace Balto., Maryland

MOTHER
14. Maiden Name Enid Emma Meeker
15. Birthplace Balto. Maryland

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School DEC 11 1945

18 (a) Funeral director Commissioner of Health
(b) Address
DEC 12 1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/8 1945, at 5:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/28 1945 to 12/8 1945 and that I last saw h. liv. alive on 12/8 1945.

Immediate cause of death	Duration
UNKNOWN HEMOLYTIC DISEASE OF UNKNOWN ORIGIN	
Due to HEMORRHAGIN[illegible] OF UNDETERMINED ORIGIN	
Due to	
Other Conditions PREMATURITY.	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autop (1) PULMONARY HEMORRHAGE (2) BLOOD IN BODY CAVITIES

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature A. Ehrenfeld
Address West Baltimore Date signed 12/9/45

VS 150

3139

G35062

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G35062

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Uniland & Laynes
(c) Hospital or institution:
West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2603 Kirk Ave
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Lorenz

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-26-45

8. AGE: Years	Months	Days	If less than one day
0		0	22 hr. 50 min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Julia Lorenz
15. Birthplace Balto. Md.

16 (a) Informant Mother
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School DEC 11 1945

18 (a) Funeral director Commissioner of Health
(b) Address

DEC 12 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-27 1945, at 1:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-26 1945 to 11-27 1945, and that I last saw her alive on 11-27 1945

Immediate cause of death Prematurity
Immature.

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Emil A. Bardenheier M. D.
Address West Baltimore General Hospital Date signed 11-27-45

VS 130

3138

G35063

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121

Registered No. G35063

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 31 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County St. Mary's
(c) City or town Charlotte Hall
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** William H. Lawson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Kate Lawson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) about 1865

8. AGE: Years	Months	Days	If less than one day
80			hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation naval

11. Industry or business

FATHER
12. Name Thomas Lawson
13. Birthplace Va.

MOTHER
14. Maiden Name ? Fleet
15. Birthplace Va

16 (a) Informant Miss Nell Meredith
(b) Address Annapolis Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/14/45 (month) (day) (year)
(c) Cemetery or crematory Christ Church
Location Middlesex Co. Va.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) (Date rec'd by registrar) (b) Huntington Md. (Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 12 1945, at 12:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/12 1945 to 12/12 1945, and that I last saw him alive on 12/12 1945.

Immediate cause of death	Duration
Circulatory Failure	2 days
Due to Diffuse Peritonitis	30 days
Due to Acute Gangrenous Appendicitis	3 days
Other Conditions Generalized atherosclerosis, Cystitis	

(Include pregnancy within 3 months of death)

Date of operation 12/12/45

Major findings of operation: Acute Gangrenous Appendicitis & of autopsy: Diffuse Peritonitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Melvin A. Johnson M. D.
Address Vannest Hospital Date signed 12/12/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35064

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 126

G35064 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2743 Guilford Avenue
(c) Hospital or institution: # 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) twelve
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2743 Guilford Avenue
(If rural give location)
(e) If foreign born, how long in U. S. A.? ..... years

3 (a) FULL NAME Marie Ann McKenzie

3 (b) If veteran, name war — no
3 (c) Social Security Account No. — none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife John M. McKenzie
6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) April 8, 1890

8. AGE: Years	Months	Days	If less than one day
55	8	4	10 hr. 40 min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Michael Reilson
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Johnson
15. Birthplace Delaware

16 (a) Informant Husband
(b) Address 2743 Guilford Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/16/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto. Md.

18 (a) Funeral director Wilson & Son Dom
(b) Address 1217 N. Eutaw St.

19 (a) ..... (b) .....
(Date rec'd by Registrar) Registrar

DEC 18 1945

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH December 12, 1945, at 10:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 10 1942, to Dec. 12 1945, and that I last saw her alive on Dec. 11 1945.

Immediate cause of death	Duration
Cirrhosis of Liver	?
Due to Unknown	
Due to	
Other Conditions Gall Bladder Disease	?

(Include pregnancy within 3 months of death)

Major findings:
Of operation Gall stones
Of autopsy Not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William B. Cole M. D.
Address 6014 York Road Date signed 12-17-45

G35065

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

53

Registered No. G35065

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address North Broadway
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 132 days
(e) Length of stay in Baltimore (yrs., mos., or days) 8 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County Anne Arundel
(c) City or town EASTPORT
(If outside city or town limits, write RURAL and give town)
(d) Street No. 812 CHESAPEAKE AVE.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME IRA MILLICAN

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	SINGLE

6 (b) Name of husband or wife NODE.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 2, 1885

8. AGE: Years	Months	Days	If less than one day
60	5	10	hr. min.

9. Birthplace MARYLAND. (Somerset Co.)
(Town, county, and state)
10. Usual Occupation OYSTERMAN
11. Industry or business FISHING.

FATHER
12. Name IRA MILLIGAN
13. Birthplace MARYLAND.

MOTHER
14. Maiden Name ANNIE HOPKINS.
15. Birthplace MARYLAND.

16 (a) Informant IRA MILLICAN
(b) Address 812 CHESAPEAKE AVE. EASTO. MD

17 (a) Burial (b) Date thereof 12/15/45
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Glen Haven
Location a. a. Co. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) (b)
(Date rec'd by registrar) Huntington Williams, M.D.

DEC 13 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-12 1945, at 7.30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from AUGUST 2 1945 to DEC. 12 1945 and that I last saw him alive on DEC 12 1945

Immediate cause of death MALNUTRATION DUE TO RECURRENT SQUAMOUS CELL EPITHELIOMA. — Duration

Due to SQUAMOUS CELL EPITHELIOMA OF — Duration

Due to POSTERIOR AURICULAR REGION (RIGHT). — Duration

Other Conditions Pulmonary emphysema generalized arteriosclerosis — Duration

(Include pregnancy within 3 months of death)

Date of operation AUGUST 7, 1943

Major findings of operation: RECURRENT SQUAMOUS CELL EPITHELIOMA

of autopsy Pulm. emphysema, arteriosclerosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James R. Little Jr. M. D.
Address Church Home & Hospital Date signed 12-12-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35066

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G35066 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2211 W. Rogers Ave
(c) Hospital or institution:
Home for the Aged of the Methodist Church
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2211 W. Rogers Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosa E. Harvey

3 (b) If veteran, name war	3 (c) Social Security Account No.
W	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife George Harvey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 24th 1868

8. AGE: Years	Months	Days	If less than one day
77	9	17	hr. min.

9. Birthplace Balto Md.
(Town, county, and state)
10. Usual Occupation Inmate
11. Industry or business Home for Aged

FATHER
12. Name Henry Schmidt
13. Birthplace Germany

MOTHER
14. Maiden Name Louise Vanicky
15. Birthplace Germany

16 (a) Informant Rosa Home for Aged of Methodist Church
(b) Address 2211 W. Rogers Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/15/45 (month) (day) (year)
(c) Cemetery or crematory Balto
Location Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) 12-10-45 (Date rec'd by registrar) (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 11th 1945; at 5 05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1945 to Dec 11 1945; and that I last saw h.. alive on Dec 11 1945

	Duration
Immediate cause of death Coronary Thrombosis	1 Day
Due to Arteriosclerosis	10 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Anthony J Davis M. D.
Address 2002 Eutaw Pl Date signed 12-12-45

VS 150

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35067

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 162B

Registered No. G35067

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2114 N Calvert St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2114 N Calvert St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Elwin Price

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Elizabeth Brinkley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 1863

8. AGE: Years 82 | Months 2 | Days | If less than one day hr. 13 min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business Private Family

FATHER 12. Name Samuel D Price
13. Birthplace Md

MOTHER 14. Maiden Name Mary Ann Carson
15. Birthplace Md

16 (a) Informant Mrs Donald Hamilton
(b) Address 3406 Oakenshaw Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/14/45 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Baltimore Md

18 (a) Funeral director Tilburg & Son
(b) Address 1214 N Fulton Ave

19 (a) (Date rec'd by registrar) (b) Registrar

Huntington Williams MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 11 1945 at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 5 1945 to Dec 11 1945 and that I last saw deceased alive on Dec 11 1945.

	Duration
Immediate cause of death: Terminal Pneumonia	
Due to: Senility	
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm H Pearce M. D.
Address 205 Eden St Date signed 12/13/45

DEC 13 1945

G35068

1420 Fe House st

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

63 B

Registered No. G35068

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 429 Colvin St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 429 Colvin St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Oliver H. Waddell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Col	M. Married

6 (b) Name of husband or wife Myrtle Waddell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years	Months	Days	If less than one day
49			hr. min.

9. Birthplace North Carolina (Town, county, and state)
10. Usual Occupation
11. Industry or business Broker

FATHER
12. Name John Wesley Waddell
13. Birthplace N. C.

MOTHER
14. Maiden Name Rosie Smitherman
15. Birthplace N. C.

16 (a) Informant Myrtle Waddell
(b) Address 1704 E. Chase St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-13-45 (month) (day) (year)
(c) Cemetery or crematory
Location Mt Calvary

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Bentley Rd

DEC 13 1945 (Date received by registrar) (b)

Huntington Williams Inc

MEDICAL CERTIFICATION

20. DATE OF DEATH 12. 9. 1945 at 4 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 12. 8 1945 to 12. 9 1945 and that I last saw him alive on 12. 9. 1945.

Immediate cause of death	Duration
Acute Dilatat. of Heart	1 day
Due to Exophthalmic Goitre	3-4 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. H. Berry M. D.
Address 1420 E. Chase Date signed 12-11-45

VS 150

X

G35069

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G35069

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 651 W. Mulberry st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 651 W. Mulberry st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Beatrice Thomas

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 12-5-1898

8. AGE: Years 47 | Months — | Days 6 | If less than one day ... hr. ... min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation House work

11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name Sarah Hill
15. Birthplace Md

16 (a) Informant Charles Quarles
(b) Address 651 W. Mulberry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-14-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore Md

18 (a) Funeral director William A Jackson
(b) Address 916 Penna ave

19 (a) ... (Date rec'd by registrar) (b) ... Registrar

DEC 13 1945 Lillington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-11- 1945 at 3:30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-20-1945 to 11-20-1945 and that I last saw h... alive on ... 19...

Immediate cause of death Cerebral accident — Duration

Due to Hypertensive cardio-vascular disease

Due to

Other Conditions Uni-lateral hemiplegia
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M.
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. R. Campbell M. D.

Address 718 Dolphin St. Date signed 12-12-45

Howard J. Mercer, M. D.

G35070 BALTIMORE CITY HEALTH DEPARTMENT G35070

CERTIFICATE OF DEATH 178a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1623 E. 31st St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
Street No. 1623 E. 31st St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine Annie Roemer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Conrad Roemer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 20, 1866

8. AGE: Years 78 | Months 11 | Days 16 | If less than one day ____ hr. ____ min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Wilhelm Schreiber
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Labrue
15. Birthplace Germany

16 (a) Informant Dorothy M. Roemer.
(b) Address 1623 E. 31st St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-15-1945 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md.

18 (a) Funeral director C. Raymond Kaufman
(b) Address 1826 Leads Ave.

19 (a) DEC 13 1945 (Date received by registrar) (Signature) for Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 11 1945, at 10 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Asphyxiation

Due to Illuminating Gas

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-11- at 9/6 P. M.
(b) Where did injury occur? 1623 E. 31st St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Gas unlit burner & gas oven.

23. Signature Howard D. Madeira M.D. Medical Examiner.
Date signed 12-12-45

(OVER)

G35071 METZGER

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

G35071 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1503 Hartford Ave.
(c) Hospital or institution: Mercy Hospital 81
(d) Length of stay in hospital or inst. (yrs., mos., or days) 31 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1503 N. Hartford Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Metzger

3 (b) If veteran of war W

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	widowed

6 (b) Name of husband or wife

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) Aug 13, 1870

8. AGE: Years	Months	Days	If less than one day: hr.	min.
70	2	29		

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Cook

11. Industry or business

FATHER
12. Name John Metzger
13. Birthplace Maryland

MOTHER
14. Maiden Name Cecilia Stumpf
15. Birthplace Germany

16 (a) Informant Son
(b) Address 1503 N Hartford Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/17/45 (month) (day) (year)
(c) Cemetery or crematory Holy Sepulchre
Location Cedar Rd.

18 (a) Funeral director Carr & Cook
(b) Address 1101-3 Patterson Place

19 (a) [illegible] (b)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 12 1945, at 8:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 27 1945 to Dec 12 1945 and that I last saw h/s alive on Dec 12 1945

Immediate cause of death Coronary Failure — Duration

Due to Arteriosclerosis

Due to Coronary Occlusion

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul R. Myers M. D.
Address Mercy Hosp. Date signed 12/12/45

VS 150 Huntington Williams, M.D.

G35072

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G35072 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1611 Balmor Ct
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 40 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1611 Balmor Ct (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Lucy Harcum

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Frank J. Harcum
6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) Feb 17 1886

8. AGE: Years 59 | Months 9 | Days 22 | If less than one day: hr. min.

9. Birthplace Richmond Co Va (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name John Taylor
13. Birthplace Richmond Co Va

MOTHER
14. Maiden Name Patsy Taylor
15. Birthplace Richmond Co Va

16 (a) Informant: Frank J. Harcum
(b) Address 1611 Balmor Ct

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/13/45 (month) (day) (year)
(c) Cemetery or crematory Arbutus
Location Md.

18 (a) Funeral director Mrs. M. Kelson
(b) Address 1303 Presstman St.

19 (a) (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 11 DEC 13 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 10 1945, at 1:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/4 1945, to 12/10 1945, and that I last saw h alive on 12/9/1945.

Immediate cause of death: Cerebral Hemorrhage — Duration

Due to: Hypertension Cardio Vas. Dis

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work
(Specify type of place)
(e) Means of injury

23. Signature H. T. Howell M.D.
Address 501 Maryland Ave Date signed 12/10/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35073

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13

G35073 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1214½ Penna ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1214½ Penna ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Eunice Bruce

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Divorce

6 (b) Name of husband or wife Butler

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/22/1922

8. AGE: Years 23 | Months 10 | Days 19 | If less than one day hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Thomas Mason

13. Birthplace Va.

MOTHER 14. Maiden Name Annie Bobley

15. Birthplace Va.

16 (a) Informant Thomas Mason

(b) Address 1214½ Penna Ave

17 (a) Burial (b) Date thereof 12/15/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory South Boston
Location South Boston, Va.

18 (a) Funeral director Geo. W. Gleason

(b) Address 1303 Broadway St

19 (a) (b) Huntington Williams, M.D.
(Date received by registrar) Registrar

DEC 15 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 10 — 1945, at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1945 to Dec 10 1945, and that I last saw h[illegible] alive on Dec 10 1945.

Immediate cause of death Pulmonary Phthisis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. D. Hatcher M. D.

Address 1725 Penna Ave Date signed 12/14/45

X

G35074 592.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

30 ✓

Registered No. G35074

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3- 3
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1206½ McCulloh St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William White

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? ?

8. AGE: Years	Months	Days	If less than one day
67 ?	?	?	hr. min.

9. Birthplace Va. ?
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Jim White
13. Birthplace Va.

MOTHER
14. Maiden Name Rosa ?
15. Birthplace Va.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-17-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cemetery
Location Md.

18 (a) Funeral director Adolphus Holstead
(b) Address 918 Druid Hill Ave.

19 (a) Registrar Huntington Williams, M.D.
DEC 13 1945
VS 110

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 12 1945, at 5:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 7 1945 to Dec. 12 1945. and that I last saw h im alive on Dec. 12 1945

Immediate cause of death: Ruptured Aneurysm of abdominal Aorta — Duration: ?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: none

of autopsy: same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature T. P. Gerrigan M. D.
Address Baltimore City Hosp. Date signed 12-13-45

X

G35075 cancel

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107 Registered No. G35075

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp 6
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 200 N. Wolfe St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lillian Olsen

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Edwin A. Olsen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 3, 1911

8. AGE: Years 34 | Months 8 | Days 7 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation House Duties

11. Industry or business

FATHER — 12. Name William J. Schmidt
13. Birthplace Baltimore Md.

MOTHER — 14. Maiden Name Lillian R. Beatty
15. Birthplace Baltimore, Md.

16 (a) Informant William J. Schmidt
(b) Address 209 Mt. Holly St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12- (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Frederick A. Cole
(b) Address 1700 W Lanvale St.
(c) DEC 13 1945 (Date received by registrar) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 10 1945, at 6:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bronchopneumonia

Due to

Other Conditions Severe Anemia

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Shtarelic M.D. Medical Examiner.
Date signed 12-11-45

X

G35076 Duplicate

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G35076 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 948 N. Duncan St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 946 N. Duncan Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Dodge

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife Warren W. Dodge
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 30, 1869

8. AGE: Years	Months	Days	If less than one day
86	2	10	hr. 19 59 min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Dietician
11. Industry or business Balto. City. Retired

FATHER
12. Name Harvey Nause
13. Birthplace Germany

MOTHER
14. Maiden Name Caroline Kirmse
15. Birthplace Germany

16 (a) Informant Mrs. Pearl Byrnes
(b) Address 2421 E. Lafayette Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-13-45 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore

18 (a) Funeral director Frederick G. Cole
(b) Address of same 20 W. Lombard St.

19 (a) DEC 13 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 10th 1945, at 4:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-14 1945 to 12/10 1945, and that I last saw her alive on 12/10 1945.

Immediate cause of death	Duration
Cerebral Arterio-sclerosis	2yrs
Due to	
Due to	
Other Conditions Hypostatic Pneumonia (Include pregnancy within 3 months of death)	X days

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide None
(b) Date of occurrence at M
(c) Where did injury occur? None (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? None (Specify type of place) While at work?
(e) Means of injury None
23. Signature Daniel Miller
Address 1500 N Bdway Date signed 12/11/45

VS 150

G35077 Trans. 3

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G35077

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1035 Hollins St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days) 22 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1035 Hollins St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles E. Burkett

3 (b) If veteran, name war
3 (c) Social Security Account No. 212-16-4556

4. Sex: M.
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Lena M. Cameron
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 15. 1871

8. AGE: Years	Months	Days	If less than one day
74	1	25	hr. min.

9. Birthplace: Burketsville, Md. (Town, county, and state)
10. Usual Occupation: Stone Mason
11. Industry or business: Retired

FATHER
12. Name: Charles E. Burkett
13. Birthplace: Burketsville, Md.

MOTHER
14. Maiden Name: Sarah Liza Martin
15. Birthplace: Virginia

16 (a) Informant: Mrs Louise Grove
(b) Address: 529 S. Riley St. Martinsbur(g)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-13-45. (month) (day) (year)
(c) Cemetery or crematory: Rosehill Va
Location: Virginia
18 (a) Funeral director: Frederick G. Cole
(b) Address: 1268 W. Lombard St
19 (a) DEC 13 (Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 10 1945, at 2:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 10 1945, to Dec 1 1945, and that I last saw him alive on Dec 1 1945

Immediate cause of death	Duration
Arteriosclerotic Cardiovascular Disease	?
Due to —	
Due to —	
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work?
(e) Means of injury —

23. Signature: Carl P. Rostberg M.D.
Address: 326 W Lombard St. Date signed 12/11/45

VS 150

G35078

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

G35078 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important. Do not abbreviate.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1637 N. Fulton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1637 N. Fulton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Rose A. Hare

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Frank Hare

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 4, 1858

8. AGE: Years 87 ~~88~~ | Months 10 11 | Days 7 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name John Dorsch
13. Birthplace Germany

MOTHER
14. Maiden Name Louisa Hohlbein
15. Birthplace Germany

16 (a) Informant Self
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/13/45 (month) (day) (year)
(c) Cemetery or crematory Western Cemetery
Location Balto. Md.

18 (a) Funeral director Wm. J. Tickner & Sons, Inc.
(b) Address North & Pa. Aves.

DEC 13 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 11 1945, at 2 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Generalized Arteriosclerosis; arteriosclerotic gangrene of leg

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Fratzer, M.D.
Medical Examiner.
Date signed Dec. 11 1945

VS 151

G35079

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G35079 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1107 Poplar Grove St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1107 Poplar Grove St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry S. Miller

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Mary E. Miller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 2 1859

8. AGE: Years	Months	Days	If less than one day
86	3	9	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Retired Shoe Crimper
11. Industry or business

FATHER
12. Name Henry Schneidmiller
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Weil
15. Birthplace Germany

16 (a) Informant Mr. Edw. C. Miller
(b) Address 3216 Westwood Ave.

17 (a) Burial (b) Date thereof 12/14/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Woodlawn, Balto. Co.

18 (a) Funeral director Wm. J. Tickner & Sons, Inc.
(b) Address North & Pa. Aves.

(a) DEC 13 1945 Name filed by registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION P

20. DATE OF DEATH December 11 1945, at 6:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 19 1945, to Dec 11 1945, and that I last saw him alive on Dec 7 1945.

Immediate cause of death	Duration
Cardio Vascular Disease	2 yrs.
Due to Coronary Thrombosis	
Due to Hypertension	2 yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William Frey M. D.
Address 1928 Penna Ave. Date signed 12/12/45

X

G35080

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G35080 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3735 S. Hanover St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3735 S. Hanover St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Edgar Cromwell

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Isabelle Cromwell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 30, 1878

8. AGE: Years	Months	Days	If less than one day
66	4 5	12 11	hr. min.

9. Birthplace A. A. Co. Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name John Cromwell
13. Birthplace A. A. Co. Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace A. A. Co.

16 (a) Informant Mr. Carson Cromwell
(b) Address 3735 S. Hanover St.

17 (a) Burial (Burial, cremation, or removal); (b) Date thereof 12/14/45 (month) (day) (year)
(c) Cemetery or crematory Friendship Cem
Location Severn A A Co. Md.

18 (a) Funeral director Wm. J. Tickner & Sons, Inc.
(b) Address North & Pa. Aves. Balto.

DEC 13 1945 Huntington Williams, Mr.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 11, 1945; at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 5 1945 to Dec 11 1945 and that I last saw h alive on Dec 11 1945

Immediate cause of death

Duration

Toxemia due to
Due to Carcinoma of the sigmoid
Due to
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel Rubin M. D.
Address 203 Cathedral Date signed

G35081

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G35081 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1104 Bonaparte Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-8
(e) Length of stay in Baltimore (yrs., mos., or days) 36 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1104 Bonaparte Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martha E. Dickey

3 (b) If veteran, name war None

3 (c) Social Security Account No. None

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Harold R. Dinkey

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 16, 1884

8. AGE: Years 61 | Months 4 | Days 25 | If less than one day hr. min.

9. Birthplace Crisfield, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John O. Davis
13. Birthplace Crisfield, Md.

MOTHER
14. Maiden Name Laura Dunn
15. Birthplace Bivalve, Md.

16 (a) Informant Mr. Harold R. Dickey
(b) Address 1104 Bonaparte Ave.

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 12/15/45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Balto. Co. Md.

18 (a) Funeral director Wm. J. Tickner & Sons, Inc.
(b) Address North & Pa. Aves. Balto. Md.

DEC 13 1945
(Date rec'd by registrar) Washington for Williams M.D. (Signature)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 11, 1945, at 4:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 14, 1945 to Dec. 11 1945, and that I last saw h alive on 19

Immediate cause of death Cardio Vascular Renal Disease
Coronary Thrombosis

Due to Coronary Disease - Heart

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation

of autopsy

Duration
Sudden
0

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leon S. Blum M.D.
Address 1065 E. Preston St. **Date signed** 12/13/45

G35082

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. G35082

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1723 Longwood St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1723 Longwood (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3.(a) FULL NAME Isabelle Tweedale

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife J.W.B. Tweedale
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March, 1 1861

8. AGE: Years	Months	Days	If less than one day
84	9	9	hr. min.

9. Birthplace Richmond Va. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Albert Bareford
13. Birthplace Richmond Va.

MOTHER
14. Maiden Name Matilda Tompkins
15. Birthplace Richmond Va.

16 (a) Informant Mr. William L Tweedale
(b) Address 1723 Longwood St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/13/45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn Md.

18 (a) Funeral director William J. Tickner & Sons
(b) Address North & Pennsylvania Aves.

19 (a) DEC 13 1945 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 10 1945 at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 6 1945 to Dec 10 1945 and that I last saw h[illegible] alive on Dec 10 1945.

Principal cause of death	Duration
Chronic Cardiac Valvular Disease	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Emmett D. Kahn
Address 736 Park Ave Date signed 12/13/45

VS 150

G35083

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

G35083 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 7
(e) Length of stay in Baltimore (yrs., mos., or days) 2

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1611 Olive Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elmer Barnes

3 (b) If veteran, name war: World War II
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Divorced.
6 (b) Name of husband or wife: —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. - 1904

8. AGE: Years ? 41 | Months 2 | Days | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Painter
11. Industry or business

FATHER
12. Name John A. Barnes
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Harriett Granger
15. Birthplace Baltimore Md.

16 (a) Informant Mrs Wm Caltrider
(b) Address 13 E. Randall St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-15-1945 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore Md.

18 (a) Funeral director Flynn & Fleming
(b) Address 1426 Light St.

19 (a) DEC 13 1945 (Date received by registrar) Hunter for Williams M.D. Registrar

MEDICAL CERTIFICATION 35

20. DATE OF DEATH December 11, 1945, at 2 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to atherosclerosis

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Shutzelie M.D. (Medical Examiner.)
Date signed 12-12-45.

VS 151

correct age is especially important. Physicians: please write the c

G35084

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. G35084

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3216 Harrison Blvd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 22 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3216 Harrison Blvd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rebecca Weisman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Edeb Weisman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1862

8. AGE: Years 83 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Benjamin
13. Birthplace Russia

MOTHER
14. Maiden Name Jacobs
15. Birthplace Russia

16 (a) Informant Mr. Sam Caplan

(b) Address 1643 N. Payson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-13-45 (month) (day) (year)

(c) Cemetery or crematory Woodlawn

Location

18 (a) Funeral director Joel Levin Inc

(b) Address 1429 E. Preston St

19 DEC 13 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 12 1945, at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1943 to Dec. 12 1945 and that I last saw her alive on Dec. 12 1945.

Immediate cause of death: Cerebral Thrombosis — Duration 1 hr

Due to: Chronic Hypertension — Duration 2 yrs

Due to: Partial Paralysis — Duration

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M J Caplan M.D.

Address 240 Eutaw Date signed 12/13/45

G35085

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1/31a

G35085
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1613 Ruxton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 38 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1613 Ruxton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sadie Bernstein

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Morris
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years 75 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Shulim Bass
13. Birthplace Russia

MOTHER
14. Maiden Name —
15. Birthplace Russia

16 (a) Informant Jos Bernstein
(b) Address 1613 Ruxton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-13-45 (month) (day) (year)
(c) Cemetery or crematory Hebrew Mt Carmel
Location

18 (a) Funeral director Jack Levine Inc
(b) Address 1945 E. Balto. St

DEC 13 1945 (Date rec'd by registrar)

(a) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-13 1945, at 12:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-4 1934 to 12-13 1945, and that I last saw h[er] alive on 12-12 1945

Immediate cause of death	Duration
Chronic nephritis	1944
Due to arterio Sclerosis	
Hypertension	1934
Due to Coronary Sclerosis	1945
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. A. Mielenhausen M. D.
Address 2230 Eutaw Pl Date signed 12/15/45

VS 150

G35086

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V186a

Registered No. G35086

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1749 Jefferson St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1749 Jefferson St.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William H. Saunders

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: Col
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Bessie Saunders
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years 58 | Months | Days | If less than one day: hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Minister

11. Industry or business

FATHER
12. Name Oscar Saunders
13. Birthplace Ala.

MOTHER
14. Maiden Name Rebecca Frantser
15. Birthplace Md

16 (a) Informant William H. Saunders
(b) Address 1617 E. Preston St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-14-45 (month) (day) (year)
(c) Cemetery or crematory Arbutus
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantly Ave

19 (a) (Date received by registrar) Washington Funeral Home

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 11th 1945, at 5:10 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from December 9th 1945 to Dec. 11th 1945 and that I last saw h[im] alive on Dec. 8th 1945

Immediate cause of death Heart - Insufficiency — Duration: unknown

Due to fractured hip. — Duration: unknown

Due to

Other Conditions arteriosclerosis. Myocardium of heart
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 12 at 6:15 M
(c) Where did injury occur? at home
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? No
(Specify type of place)
(e) Means of injury Slipped and fell on floor

23. Signature Earl Crawford M. D.
Address Lombardy Apartments Date signed 12-11-45

Howard J. Andrews, M.D. X

G35087

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

166

G35087 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Dundalk (If outside city or town limits, write RURAL and give town)
(d) Street No. 505 Colfax Way (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Mitchell

3 (b) If veteran, name war: World War 2

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Frances Mitchell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-25-12

8. AGE: Years 33 | Months 4 | Days 17 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Howard Mitchell
13. Birthplace

MOTHER
14. Maiden Name Henrietta Heath
15. Birthplace

16 (a) Informant Raymond Mitchell
(b) Address 1702 Division St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/17/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 6000 Brantley Ave Huntingtown Prince Georges Co. Md

DEC 13 1945 (Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 11, 1945 at 3:10 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Rest death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH
Gunshot wound left chest

[redacted]

Other Conditions Internal hemorrhage.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1:05 AM 12-11-45
(b) Where did injury occur? Town (1301 E. Lombard St)
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Shooting

23. Signature Benedict Skotarlis M.D. (Medical Examiner)
Date signed 12-11-45

G35088
JL - 97426

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

186a

G35088
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.,
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2211 Hanmann Ave.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Eldridge

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife William D. Eldridge
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 11, 1858

8. AGE: Years	Months	Days	If less than one day
87	3	0	hr. min.

9. Birthplace BALTIMORE, MARYLAND
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Washburn
13. Birthplace England

MOTHER
14. Maiden Name Mary ?
15. Birthplace England

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-14-45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, Inc
(b) Address NORTH AVE. & BROADWAY

DEC 13 1945
(Date received by Registrar)
Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 11 19 45 at 12:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 21 1945, to Dec. 11 1945, and that I last saw her alive on Dec. 11 1945.

Immediate cause of death Bronchopneumonia — Duration 48 hrs.
Due to Senility & Arteriosclerotic Cardiovascular Disease — ?
Due to — ?
Other Conditions Fract. L. Femur (mid Intertrochanteric) INTERTROCHANTERIC — 1 mo
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident 8/4
(b) Date of occurrence 11/21/45 at ? M
(c) Where did injury occur? Home
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? no
(Specify type of place)
(e) Means of injury Fall

23. Signature E. H. Perry M.D.
Address 2021 Date signed 12/13/45 M. D.

For Joseph L. Steadman, City Health Officer, Howard J. Morris, M.D.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35089

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G35089 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Md.
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1422 W. Fayette St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Henry John Maendt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Rose

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 26 1875

8. AGE: Years	Months	Days	If less than one day
68	11	14	hr. min.

9. Birthplace Maryland (town, county, and state)

10. Usual Occupation Retired
11. Industry or business Farmer

FATHER
12. Name Gus Maundt
13. Birthplace Germany

MOTHER
14. Maiden Name Winifred Flog
15. Birthplace Ireland

16 (a) Informant Mrs. Rose Maundt (b) Address Denton, Caroline County

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-15-45 (month) (day) (year)

(c) Cemetery or crematory Holly Cross Cemetery Location Westminster, Maryland

18 (a) Funeral director Joseph Hunter & Sons (b) Address Denton, Maryland

19 (a) Date received DEC 13 1945 (b) Baltimore, Md. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 10, 1945, at 1:30 P. M.

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardio-vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Distarelis M.D. Medical Examiner.
Date signed 12-10-45.

X

G35090 BALTIMORE CITY HEALTH DEPARTMENT G35090

CERTIFICATE OF DEATH 1937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 11 S. Ellwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 11 S. Ellwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Birdie E. Thompson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 31, 1879

8. AGE: Years	Months	Days	If less than one day
66	3	11	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Dressmaker
11. Industry or business

FATHER 12. Name Myron Palmer
13. Birthplace New York

MOTHER 14. Maiden Name Ethlyn S. Hunter
15. Birthplace Harford County, Md

16 (a) Informant Robert T. Thompson.
(b) Address 2924 E. Fayette St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/15/45 (month) (day) (year)
(c) Cemetery or crematory Abingdon M. E. Cemetery
Location Abingdon, Md.

18 (a) Funeral director Howard H. Blight Jr.
(b) Address 4914 Belair Road.

19 DEC 13 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH December 11, 1945, at 7:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 15, 1942 to Dec. 11, 1945 and that I last saw her alive on Dec. 11, 1945

Immediate cause of death	Duration
Cerebral Hemorrhage	3 days
Due to Myocarditis	4 years
Arteriosclerosis	Unknown
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Philibert Artigiani M. D.
Address 2942 E. Fayette St. Date signed 12/13/45

Philibert Artigiani

VS 150

G35091

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G35091 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Belvedere Ave
(c) Hospital or institution: Hebrew Home for Aged 27
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 17 Greenspring & Belvedere (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hyman Lepidits (HYMAN LIPSCHITZ)
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	S

6 (b) Name of husband or wife —
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years	Months	Days	If less than one day
70			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Mom
11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Wife Brother
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-13-45 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location German Infl Rd
18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E. Balto St
19 (Date rec'd by registrar) DEC 13 1945 Hunting for Williamsburg

MEDICAL CERTIFICATION

20. DATE OF DEATH December 11 1945, at 5 P. M
21. I certify that death occurred on the date above stated; that I attended deceased from 3-28 1945, to 12-11 1945, and that I last saw h-him alive on 12-11 1945.

Immediate cause of death	Duration
Chr. valvular heart disease	
Diabetes Mellitus.	
Due to	
Due to	
Other Conditions	
(Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature H. Edmund Levin
Address Levindale Date signed 12/11/45

VS 150

G35092

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G35092

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St. & Rutland Ave
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2038 E. Fairmount Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Ethel Dudick

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race wh

6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Solomon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years 60 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace Russia
(Town, county and state)

10. Usual Occupation Domestic work

11. Industry or business

FATHER
12. Name Solomon [illegible]
13. Birthplace Russia

MOTHER
14. Maiden Name Shapdel
15. Birthplace Russia

16 (a) Informant Solomon Dudick
(b) Address 2038 E. Fairmount Ave

17 (a) Burial (b) Date thereof 12-13-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location

18 (a) Funeral director Jack Myers Inc
(b) Address 1439 E. Balto. St

19 (a) 12-12-1945 Attention for William Deering
(Date received by local registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-12-45 19 , at 7:00 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/8/ 1945 to 12/12/1945 and that I last saw h er alive on 12/12/45 19

Immediate cause of death Uraemia — Duration

Due to Arteriosclerotic & Hypertension Heart disease

Due to

Other Conditions Left Hemiplegia (Art. ces. Vas. accident)
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Bertha Rader M. D.

Address Sinai Hosp Date signed 12/12/45

G35093

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 109a

Registered No. G35093

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2208 Wilkins Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2208 Wilkins Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Margaret M. Fitzgerald

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed~~, or divorced.
Female	White	Married

6 (b) Name of ~~husband~~ or wife Edward M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 17 1906

8. AGE: Years	Months	Days	If less than one day
39	10	24	hr. min.

9. Birthplace Scotland
(Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William Gall
13. Birthplace Scotland

MOTHER
14. Maiden Name Margaret Cunard
15. Birthplace Scotland

16 (a) Informant Edward M. Fitzgerald
(b) Address 2208 Wilkins Ave

17 (a) Burial (b) Date thereof Dec 15 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Harford Road

18 (a) Funeral director John A Moran
(b) Address 3005 E Baltimore St

DEC 13 1945
(Date filed by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 11 1945, at 7 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/7 1945 to 12/11 1945.
and that I last saw h~~e~~r alive on 12/10 1945

Immediate cause of death: Virus Pneumonia
acute Cardiac Failure

Duration
2 day
1 day

Due to —

Due to

Other Conditions —
(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A Gales M. D.
Address 47 N Fulton Date signed 12/12

VS 150

The G35094

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1310

Registered No. G35094

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Exact age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd and Calvert
(c) Hospital or institution: The Union Memorial Hosp 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2929 Berwick ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Joan Evelyn Steelper

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 1 1942

8. AGE: Years	Months	Days	If less than one day
3	1	12	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Louis N Steelper
13. Birthplace Maryland

MOTHER
14. Maiden Name Ethel Dawes
15. Birthplace Maryland

16 (a) Informant Mr. Louis N. Steelper
(b) Address 2929 Berwick Ave.

17 (a) Burial (b) Date thereof 12-15-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Rd.

(a) DEC 13 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 13 1945, at 5 50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 7 1945, to Dec 13 1945 and that I last saw LET alive on Dec 13 1945.

Immediate cause of death Coronary Thrombosis of glomerular nephritis — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Mary Raynard Strealin M. D.
Address Date signed

VS 150

X

G35095

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

124B

Registered No. G35095

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: U. S. Marine Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Pikesville (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Grady C. Rogers (Grady Clarence Rogers)

3 (b) If veteran, name war WORLD WAR #1

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1894

8. AGE: Years 51 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace GREENVILLE, ALA. (Town, county, and state)

10. Usual Occupation AUTO SALESMAN

11. Industry or business CLEMENT MOTOR CO.

FATHER
12. Name JOHN ROGERS
13. Birthplace ALA.

MOTHER
14. Maiden Name (?) GRADY
15. Birthplace ALA.

16 (a) Informant DUNKLIN & JOHNSON FUNERAL HOME
(b) Address GREENVILLE, ALA.

17 (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof DEC. 13, 1945 (month) (day) (year)
(c) Cemetery or crematory GREENVILLE
Location GREENVILLE, ALA.

18 (a) Funeral director WILLIAM COOK, INC.
(b) Address 1217 ST. PAUL ST.

DEC 13 1945 (Date rec'd by Registrar) Huntington for Williams M.D. Registrar

MEDICAL CERTIFICATION

19. DATE OF DEATH 12-9- 45, at 4:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Ruptured esophageal varices

Due to

Other Conditions Portal cirrhosis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Schaeffer M.D. Medical Examiner
Date signed December 10, 1945

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

G35096

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G35096

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. This correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Ave
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11mo 2day
(e) Length of stay in Baltimore (yrs., mos., or days) 11mo 2day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Frederick
(c) City or town St Joseph's Central House
(If outside city or town limits, write RURAL and give town)
(d) Street No. Emmitsburg Maryland
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Sister Anna Nast

3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ✓

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: single
6 (b) Name of husband or wife ✓
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Dec 25. 1875
8. AGE: Years 69 | Months 11 | Days 18 | If less than one day hr. min.
9. Birthplace Philadelphia, Pa
(Town, county, and state)
10. Usual Occupation Sister of Charity
11. Industry or business

FATHER
12. Name Joseph Nast
13. Birthplace Edenkuhle Germany

MOTHER
14. Maiden Name Julia Stein
15. Birthplace Koblenz, Germany

16 (a) Informant St. Agnes Hospital
(b) Address Caton & Wilkens Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/14/45 (month) (day) (year)
(c) Cemetery or crematory Catholic
Location Baltimore

18 (a) Funeral director Martin Tabb Funeral Home
(b) Address 1827 N. North Ave

19 DEC 13 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/12/45 1945 at 8:05 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/10 1945 to 12/12 1945 and that I last saw h alive on 19

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Hypertensive Cardio-Vascular disease	
Due to	
Other Conditions Diabetes Mellitus	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Arthur T. Hall Jr. M.D.
Address St. Agnes Hosp. Date signed 12/13/45

VS 150

92D

G35097

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

117 B

G35097 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County Anne Arundel
(c) City or town Hanwood
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Thomas Duvall

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Sadie Duvall

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 66 | Months | Days | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name James
13. Birthplace Md.

MOTHER 14. Maiden Name Nancy Bromford
15. Birthplace Md.

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 15 45 (month) (day) (year)
(c) Cemetery or crematory Catholic Cemetery
Location Severnaville, Md.

18 (a) Funeral director J. A. Handley & Son
(b) Address Odenville, Md.

19 (a) DEC 13 1945 (Date received by registrar) (b) [illegible] Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH December 12 1945, at 10:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-30 1945 to 12-12 1945, and that I last saw him alive on Dec 12 1945.

Immediate cause of death	Duration
Emphysema - gangrene of Left Lung & pleural fluid	
Due to Infected Lung cyst or Septic Infarct?	
Due to	
Other Conditions duodenal ulcer & inflammatory mass & obstruction (Include pregnancy within 3 months of death)	

Date of operation 11-30-45

Major findings of operation: duodenal obstruction (ulcer)

of autopsy Emphysema L. Lung, Purulent pleurisy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Osmund Wiesner M. D.
Address Univ. Hosp. Date signed 12-13-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35098

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92 B

G35098 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1410 N. Broadway
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1410 N. Broadway.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Margaret L Campbell

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband ~~or wife~~ Albert P. Campbell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 24

8. AGE: Years 85 | Months 10 5 | Days 10 9 | If less than one day hr. min. 18 60

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John F. Hill
13. Birthplace Salisbury

MOTHER
14. Maiden Name Priscilla Sanders
15. Birthplace Port Deposit

16 (a) Informant Dora F. Dietz
(b) Address 1410 N. Broadway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 14 46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto Md.

18 (a) Funeral director Agnes A. Lutz
(b) Address 1203 N Broadway

19 (a) (b) Huntington Indiana Ind. Registrar

Date received by registrar DEC 14 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 12 1945, at 3A M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-5 1942, to 12-12 1945, and that I last saw h~~er~~ alive on 12-12 1945.

	Duration
Immediate cause of death: Intest Stenosis	6 yrs
Due to:	
Due to:	
Other Conditions: Myocardial Degeneration	6 days

(Include pregnancy within 3 months of death)

Major findings:
Of operations:

Of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dallas Miller M.D.
Address 1500 N Broadway Date signed 12/13/45

G35099

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 182a

G35099 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1907 Aliceanna St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helen M. Grynowicki

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.: NONE

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY 15 1945

8. AGE: Years | Months: 6 | Days: 28 | If less than one day: hr. min.

9. Birthplace BALTIMORE MD. (Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER
12. Name ADAM GRYNOWICKI
13. Birthplace BALTO.

MOTHER
14. Maiden Name VIOLA RYAN
15. Birthplace BALTO.

16 (a) Informant ADAM GRYNOWICKI(FATHER)
(b) Address 1907 ALICEANNA ST.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/14/45 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Gorman Mill Rd

18 (a) Funeral director Lilly & Zerter-Doe
(b) Address 403 S. Wolfe St

19 (a) DEC 14 1945 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 13 1945, at 6 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Asphyxiation (in bed)

Due to

Other Conditions Enlarged thymus

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Dec. 13 1945 4:47 P.M.
(b) Where did injury occur? 1907 Aliceanna St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Suffocation due to bed clothes?

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed Dec 13 1945

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRINT, WITH UNFADING INK.

G35100

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

122B

Registered No. G35100

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital 2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1320 James St (If rural give location)
(e) Citizen of foreign country (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Lula Schafer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) ~~Single~~, (married) ~~widowed, or divorced~~

6 (b) Name of husband or wife Dead

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 7 - 1873

8. AGE: Years 72 Months 10 Days 6 If less than one day hr. min.

9. Birthplace Lifetime Balto (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Fred Bugle

13. Birthplace Germany

MOTHER 14. Maiden Name Not Known

15. Birthplace Germany

16 (a) Informant B. Preis

(b) Address 1320 James St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/17/45 (month) (day) (year)

(c) Cemetery or Crematory Loudon Park

Location Frederick Ave

18 (a) Funeral director Geo Leppluch

(b) Address 1 W N Lyndhurst St

19 (a) DEC 14 1945 (Date rec'd by registrar) Hunting Town Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 13 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-[redacted]5 1945 to 12/13 1945 and that I last saw h[redacted] alive on 12/13 1945.

Immediate cause of death Respiratory Failure — Duration

Due to Hypostatic Pneumonia

Due to Intestinal obstruction over

Other Conditions Growth rec Sigmoid

(Include pregnancy within 3 months of death)

Date of operation 12/9/45

Major findings of operation Intestinal obstruction by Cancer growth - Sigmoid

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [redacted] M.D.

Address [redacted] Date signed 12/13/45

X Hosp

635101
483997

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 32a

635101
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Parkville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7916 Oakdale Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Edward Andrews.

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-10-45

8. AGE: Years | Months: 9 | Days: 3 | If less than one day: hr. min.

9. Birthplace md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Edward H Andrews.
13. Birthplace md.

MOTHER
14. Maiden Name Madeline Smith
15. Birthplace md

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Dec 14/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Geo M Fink Sons

18 (a) Funeral director
(b) Address 811 N Wolfe St

DEC 14 1945 (b) Registrar
(Date rec'd by Registrar)
Washington Williams, MD

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH Dec-13 1945, at 7.15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 20 1945, to Dec-13 1945, and that I last saw him alive on Dec-13 1945.

	Duration
Immediate cause of death: Cardiac failure	
Due to: Toxemia	1 day
Due to: Hemorrhagic pharyngitis (etiology unknown)	16 hr.
Other Conditions: Influenzal Bronchopneumonia, terminal	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J M Morrison Jr.
Address Johns Hopkins Hosp Date signed M. 12 D. 15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

No. G35102

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

82a

Register No. G35102

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2413 Montebello Terrace
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2413 Montebello Terrace (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Maud H. Williams
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex: Female
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Ernest
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) April 5, 1894
8. AGE: Years 51 | Months 8 | Days 6 | If less than one day hr. min.
9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Lowell Williams
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Lotta R. Harris
15. Birthplace Baltimore, Md.

16 (a) Informant Ernest Williams
(b) Address 2413 Montebello Terrace

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 14, 1945 (month) (day) (year)
(c) Cemetery or crematory Laurel Cem.
Location Baltimore, Md.

18 (a) Funeral director Wm. Chas. H. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) DEC 14 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

2139

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/11 1945, at 5 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/3 1945 to 12/11 1945 and that I last saw her alive on 12/8 1945.

Immediate cause of death: Cerebral Hemorrhage
Due to: Paralysis
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature B. M. Rhetton M. D.
Address 2179 Druid Hill Ave. Date signed 12-14-45

B. M. Rhetton

G35103

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G35103 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1713 Etting St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 1713 Etting St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Edwards

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 9, 1883

8. AGE: Years 62 | Months 4 | Days 2 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Painter

11. Industry or business

FATHER 12. Name Unknown
13. Birthplace

MOTHER 14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Alverta Holmes
(b) Address 1713 Etting St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 14, 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Chas. H. Stuckart
(b) Address 1651 Druid Hill Ave.

19 DEC 14 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 11 1945, at 11 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 13 1945, to Dec 11 1945, and that I last saw him alive on Dec 1 1945.

Immediate cause of death Chronic Arthritis — Duration 6 mos.

Due to Cardio Vascular Disease — 5 mos.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Emmett Frey M. D.
Address 1938 Pennsylvania Ave. Date signed 12/14/45

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

35104

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G35104

Registered No. 3698

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 825 N. Gilmor
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or ~~town~~ Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 825 N. Gilmor
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian Green

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Col	

6 (b) Name of husband or wife Walter Green
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 28-1910

8. AGE: Years	Months	Days	If less than one day
35	1	15	hr. min.

9. Birthplace Baltimore
(Town, county, or state)
10. Usual Occupation Elevator Operator
11. Industry or business

FATHER
12. Name George Jennings
13. Birthplace Md

MOTHER
14. Maiden Name Frances Spriggs
15. Birthplace Md

16 (a) Informant Walter Green
(b) Address 2001 Madison Ave

17 (a) Burial (b) Date of [illegible] Dec 13 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore

18 (a) Funeral director Sam'l F. Chase Wm
(b) Address 6387 N. Gilmor St

19 DEC 14 1945 Huntington, W. Va.
(Date received by local registrar) (Signature of local registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 — 13 — 1945, at 2:55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-11-1945 to 12-13-1945, and that I last saw her alive on 12-12-1945

Immediate cause of death	Duration
Cerebral hemorrhage	2 days
Due to	
Due to Arteriosclerosis	unknown
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John D. Saunders M. D.
Address 40 Eq N. Strayer Date signed 12-13-45

X

635105

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V170c

635105

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 416 North Port Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John H. Weller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Sophia Weller

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 24-1872

8. AGE: Years 73 | Months 7 | Days 17 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Black Smith

11. Industry or business

FATHER
12. Name Michal Weller
13. Birthplace Germany

MOTHER
14. Maiden Name Not Known
15. Birthplace Not Known

16 (a) Informant Clifton Weller
(b) Address 809 E. Chester St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof dec. 15-45 (month) (day) (year)
(c) Cemetery or crematory Immanuel Cem.
Location Grindon Lane

18 (a) Funeral director John A. Miller
(b) Address 2534 Jefferson St.

DEC 14 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 12, 1945 at 9 45 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Intracranial Hemorrhage traumatic Fracture of Ribs, right with Pneumothorax

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 6/2
(a) Date of injury 11-26-45 at 9 P. M.
(b) Where did injury occur? In front of 2407 Jefferson St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian struck by auto.

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Dec. 12 1945

VS 151

X

G35106

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 169

Registered No. G35106

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1731 N Milton ave
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1731 N. Milton Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Johnson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	Married

6 (b) Name of husband or wife Mary E Johnson

6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) Aug 27, 1885

8. AGE: Years	Months	Days	If less than one day
60	3	16	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Engineer.

11. Industry or business Locomotive

FATHER
12. Name John H Johnson
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Bell
15. Birthplace England

16 (a) Informant Mary E Johnson
(b) Address 1731 N Milton ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 17 '45 (month) (day) (year)

(c) Cemetery or crematory Woodland Memorial Park
Location Rural

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Mclean St

19 (a) DEC 1 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 12, 1945, 12 8 P M

21. I certify that I took charge of the remains described above, held an Inspection & Partial autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Intracranial hemorrhage, traumatic.

Due to

Other Conditions Fracture, both legs.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Dec 12, 1945 12/5 M.
(b) Where did injury occur? Penna. Station
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? Yes
(d) Means of injury Thrown from train - striking against moving object

23. Signature Chas E Gratton M.D. Medical Examiner.

Date signed Dec 12 1945

263

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied. The

G35107

BALTIMORE CITY HEALTH DEPARTMENT

HB # 97626

CERTIFICATE OF DEATH

13B

Registered No. G35107

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 1½ Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 911 Spangler Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gilbert Lawrence King

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Separated

6 (b) Name of husband or wife Lida King
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 16, 1880

8. AGE: Years	Months	Days	If less than one day
65	9	16	hr. min.

9. Birthplace Pulaski County Va.
(Town, county, and state)
10. Usual Occupation Electrical dept
11. Industry or business Sparrows Pt

FATHER
12. Name William King
13. Birthplace Va.

MOTHER
14. Maiden Name ? Jones
15. Birthplace Va.

16 (a) Informant Balto. City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof Dec 14th
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Hill Cem
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2006 Orleans St
(a) (Signature of person by whom burial was made) (b) Registrar

DEC 14 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 12, 1945, at 5:20AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1, 1945 to Dec. 12, 1945 and that I last saw h 1m alive on Dec. 12, 1945.

Immediate cause of death	Duration
Pulmonary Tuberculosis	
Due to	
Due to	
Other Conditions Chronic cholecystitis + cholelithiasis.	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Lung and Liver

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert B. Leland Jr. M. D.
Address Balt. City Hosp. Date signed 12/12/45

G35108

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G35108

MR # 16226

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 6 6 16-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1903 W. Lanvale St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maurice Williams

3 (b) If veteran, name war: None

3 (c) Social Security Account No. None

4. Sex: Male

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March, 9 1863

8. AGE: Years 82 | Months 9 | Days 3 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Williams
13. Birthplace Md.

MOTHER
14. Maiden Name Johanna Eggleston
15. Birthplace Md.

16 (a) Informant Balto. City Hospitals (Records)
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/15/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore, Md.

18 (a) Funeral director Wm. J. Tickner & Sons, Inc.
(b) Address North & Pa. Aves. Balto. Md.

DEC 14 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION PM

20. DATE OF DEATH Dec. 12, 1945 at 12:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 6, 1936 to Dec. 12, 1945 and that I last saw h... alive on Dec. 12, 1945

Immediate cause of death: Coronary occlusion — Duration

Due to arteriosclerotic heart disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Eugene A. Rebouillat M. D.

Address B.C.H. Date signed 12-13-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35109

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1107

G35109 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3040 Guilford Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3040 Guilford Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fannie E. Ford

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife William George Ford
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 29, 1857

8. AGE: Years	Months	Days	If less than one day
88	3	14	hr. min.

9. Birthplace Milwaukee, Wisconsin
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Henry Durbin
13. Birthplace London, England

MOTHER
14. Maiden Name ANN E. Jeffreys
15. Birthplace ?

16 (a) Informant Mrs. Emma C. H. Rivers
(b) Address 3040 Guilford Ave.

17 (a) Burial (b) Date thereof 12/15/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Park Cem.
Location Woodlawn Md.

18 (a) Funeral director Wm. J. Tickner & Sons Inc.
(b) Address North & Pa. Ave.

DEC 14 1945 Huntington Williams, M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION P

20. DATE OF DEATH December 13, 1945, at 1:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 8 1945 to Dec 13 1945 and that I last saw h[illegible] alive on Dec 12 1945.

Immediate cause of death — Duration

Bronchio-pneumonia — 5 days

Due to agenia.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. B. Truman Hood, M. D.
Address 2200 Garrison Blvd Date signed 12-18-45

635110

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. 635110

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 802 Walmut Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 802 Walmut Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) FULL NAME Cora Bolton Lambeth

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 12, 1872

8. AGE: Years	Months	Days	If less than one day
73	7	1	hr. min.

9. Birthplace Richmond, Va.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Charles Wesley Lambeth
13. Birthplace Richmond

MOTHER
14. Maiden Name Annie Pestross
15. Birthplace Va.

16 (a) Informant Mr. Ernest Lambeth
(b) Address B & O. Building Balto 1 Md.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 12/15/45 (month) (day) (year)
(c) Cemetery or crematory Oakwood Cemetery
Location Raleigh, N. C.

18 (a) Funeral director Wm. J. Tickner & Sons, Inc.
(b) Address North & Pa. Aves. Baltimore

19 DEC 14 1945 (Date rec'd by registrar) Permit for Williamsville

MEDICAL CERTIFICATION

20. DATE OF DEATH December 15, 1945, at 2 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 10 1945, to Dec 13 1945, and that I last saw h[illegible] alive on Dec. 12 1945.

Immediate cause of death	Duration
Cerebral Hemorrhage	2 hrs
Due to Renal Artiris	
Due to Uremia	✓
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ✓
(b) Date of occurrence ✓ at M
(c) Where did injury occur? ✓
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ✓ While at work?
(Specify type of place)
(e) Means of injury ✓
23. Signature [illegible]
Address 721 Poplar Grove Date signed 12/15/45

VS 150

G35111

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122B

G35111 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2213 Cecil Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days): 9-8
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2213 Cecil Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Hechmer

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife:
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 31, 1875

8. AGE: Years 70 | Months 4 | Days 10 | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Christian Hechmer
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Detrich
15. Birthplace Md.

16 (a) Informant Mrs. Christiana Young
(b) Address 2213 Cecil Ave.

17 (a) Burial (b) Date thereof 12?14/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon
Location Baltimore, Md.

18 (a) Funeral director Wm. J. Tickner & Sons, Inc.
(b) Address North & Pa. Aves. Baltimore Md.

19 (a) DEC 14 1945 Huntington Williams M.D.
(Date rec'd by registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

A

20. DATE OF DEATH Dec. 11, 1945, at 9:36 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/9 1945 to 12/11 1945; and that I last saw him alive on 12/9 1945.

Immediate cause of death: Intestinal obstruction (Strangulation) — Duration: 3 days

Due to:

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Benjamin Miller M.D.
M. D.

Address 1030 Wilkens Date signed 12/15

ark X

G35112

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G35112
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3824 Pennington Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3824 Pennington Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Virginia L. Kircher

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: late William J.

6 (c) If alive, give age Years

7. Birth date of deceased (mo., day, yr.) June 13, 1873

8. AGE: Years 72 | Months 6 | Days | If less than one day: hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Valentine Haas
13. Birthplace Maryland

MOTHER 14. Maiden Name Cornelia Jackson
15. Birthplace Maryland

16 (a) Informant Mrs. William J. Kircher
(b) Address 3824 Pennington Ave

17 (a) Burial (b) Date thereof 12/17/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Cedar Hill
Location Point Brooklyn Md

18 (a) Funeral director Harry H. Wilson
(b) Address 4016 Edmondson Ave

19 DEC 14 1945 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH December 13 1945, at 8:30a M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1945 to Dec 13 1945, and that I last saw her alive on Dec 13 1945.

Immediate cause of death	Duration
coronary occlusion	
Due to hypertensive cardio vascular disease	
Due to —	
Other Conditions —	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. W. Kuster, MD
Address 302 Calaprese Rd Date signed 12/13/45 M.D.

VS 150

G35113

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 169

Registered No. G35113

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Gen'l Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. ~~1809 the Embassy Apt~~ 5239 Kramme Ave. B.K.
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph ~~James~~ B. Clark

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Madeline C. nee Rosendale 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 19, 1921

8. AGE: Years 24 ~~Mos~~ | Months 7 | Days 22 | If less than one day ... hr. ... min.

9. Birthplace Louisville Ky.
(Town, county, and state)

10. Usual Occupation Brakeman

11. Industry or business B. & O. R. R.

FATHER 12. Name Joseph P. Clark
13. Birthplace Ky.

MOTHER 14. Maiden Name Lillian Nelson
15. Birthplace Ky.

16 (a) Informant Mrs. Madeline C. Clark
(b) Address 5239 Kramme Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/15/45 (month) (day) (year)

(c) Cemetery or crematory New Cathedral
Location 3000 Old Frederick Rd

18 (a) Funeral director Harry A. Witzke
(b) Address 1401 Edmondson Ave.

DEC 14 1945 (Date rec'd by registrar) Huntington for Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION 45

20. DATE OF DEATH Dec. 11 1945, at 7 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Hus death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushed Body

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Dec. 11 1945 25/6 7 P M.
(b) Where did injury occur? Chesapeake & Marysville Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? Yes
(d) Means of injury Crushed between freight cars

23. Signature Robert Lee Grimm M.D.
Medical Examiner.
Date signed Dec. 12 1945

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M. D. B. 1203-0

HEALTH DEPARTMENT—CITY OF BALTIMORE

G35114

CERTIFICATE OF DEATH 107

G35114

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1202 McElderry Ct St., ... Ward)

Registered No. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ..... yrs. 18 mos. ..... ds. How long in U. S. If of foreign birth? ..... yrs. ..... mos. ..... ds.

2. FULL NAME James E. Perry, Jr.

(a) Residence: No. 1202 McElderry Ct. Apt A2 St., 5-1 Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, year) June 5, 1944

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	6 18	7	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. none

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. none

10. Date deceased last worked at this occupation (month and year) —

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Baltimore Maryland

FATHER

13. NAME James E. Perry, Sr.

14. BIRTHPLACE (city or town) (State or country) Suffolk Virginia

MOTHER

15. MAIDEN NAME Evelyn Copeland

16. BIRTHPLACE (city or town) (State or country) Suffolk Virginia

17. INFORMANT James E. Perry, Sr.
(Address) 1202 McElderry Ct. Apt A2

18. BURIAL, CREMATION, OR REMOVAL
Place Mt Calvary Cemetery Date Dec 14, 19 45

19. UNDERTAKER [illegible]
(Address) 1515 McElderry St

20. DEC 14 1945 21. Hunting & Williams

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Dec 12, 1945

22. I HEREBY CERTIFY, That I attended deceased from Dec 7, 1945 to Dec 12, 1945
I last saw him alive on Dec 12, 1945. Death is said to have occurred on the date stated above, at 12:20 Am.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Bronchopneumonia	12-7-45

Other contributory causes of importance:

Name of operation None Date of

What test confirmed diagnosis? Clinical Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? ..... Date of injury ..... 19 .....

Where did injury occur? .....
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place .....

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased?
No If so, specify .....

(Signed) John E. J. Compher, M. D.

(Address) 639 N. Carey St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

635115
483542

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. 635115

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 214 Calvin St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Fannie Baxter

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	married

6 (b) Name of husband or wife Thos.
6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) 3-27-89

8. AGE: Years	Months	Days	If less than one day
56	8	16	....hr. ....min.

9. Birthplace md (Town, county, and state)
10. Usual Occupation House-wife
11. Industry or business

FATHER
12. Name Raleigh Bailey.
13. Birthplace 2.

MOTHER
14. Maiden Name Hattie 2.
15. Birthplace 2.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec-14-45 (month) (day) (year)
(c) Cemetery or crematory Westminster Cemetery
Location Baltimore Md
18 (a) Funeral director Robert F. Kelly
(b) Address 1315 McElderry St
19 (a) (Date rec'd by registrar) (b) Registrar

DEC 14 1945
Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 12. 1945, at 9.40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 17 1945, to Dec. 12 1945, and that I last saw him alive on Dec. 12 1945;

Immediate cause of death Cerebrovascular accident — Duration
Due to Uremia — Chronic glomerulonephritis
Due to Hypertensive — Arteriosclerotic disease
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William J. Dixon
Address Johns Hopkins Hospital Date signed 12/18/45

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35116

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G35116 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 139 W Hennetta St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23
(e) Length of stay in Baltimore (yrs., mos., or days) 5

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 139 W Hennetta (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3. (a) FULL NAME Baby Patricia Mc Millon

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/13/45

8. AGE: Years | Months | Days | If less than one day 6 hr. min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER 12. Name Harry Adams
13. Birthplace S C

MOTHER 14. Maiden Name Inell McMillon
15. Birthplace S C

16 (a) Informant Daisy McMillon
(b) Address 139 W Hennetta St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/14/45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balto City

18 (a) Funeral director Isaiah T. Brandon
(b) Address 108 W Montgomery St

19 DEC 14 1945 (Date rec'd by reg.) Huntington Williamsburg, M.N

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 13 1945, at 3 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 13 1945 to Dec 13 1945, and that I last saw h alive on Dec 13 1945.

Immediate cause of death Premature Birth — Duration 6 hours

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dr Coley Shelton M.D.
Address 9[illegible] Date signed 12/14/45

VS 150

G35117
JL - 90490

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 83B

Registered No. G35117

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-1-10 22
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town) 12
(d) Street No. 500 W. Montgomery St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rudolph Cook

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10, 1892

8. AGE: Years	Months	Days	If less than one day
53	6	2	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Samuel Cook
13. Birthplace Md.

MOTHER
14. Maiden Name Mamie Golden
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 12/15/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto National
Location Balto City

18 (a) Funeral director Daniel L. Brown & Son
(b) Address 108 W. Montgomery St

19 DEC 14 1945 (b) Huntington Williamson, M.D.
(Registrar's signature)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 12, 1945, at 3 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 2, 1944 to Dec. 12 1945, and that I last saw him alive on Dec. 12 1945.

Immediate cause of death	Duration
Cerebral thrombosis	?
Due to arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: none
of autopsy: not reported not

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature T. S. Jerveson M. D.
Address Baltimore City Hosp. Date signed 12-13-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

~~G35118~~

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

51B

G35118 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 10 W. Hill St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 22
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 10 W. Hill St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michael Leo Healey

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	widowed

6 (b) Name of husband or wife Louise Wessell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 16, 1866

8. AGE: Years	Months	Days	If less than one day
78 79	11	26	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Retired Police officer
11. Industry or business

FATHER
12. Name Patrick Healey
13. Birthplace Ireland

MOTHER
14. Maiden Name Bridget Gately
15. Birthplace Ireland

16 (a) Informant Miss Irene Healey
(b) Address 833 Park Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 14/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick, Md.

18 (a) Funeral director Daniel Funeral Home
(b) Address 216 N. Charles St.

19 (a) DEC 14 1945 Registrar
(b) Registered (Registrar)
Huntington Williams, M.D.

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 11 1945, at 7:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/26/1944, to 12/11 1945, and that I last saw him alive on 12/11/1945.

Immediate cause of death Malignancy of prostate with general metastases — Duration 1½ to 2 years

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry Deitel M.D.
Address 1226 Hanover St Date signed 12/13/45

X

635119

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47

Registered No. 635119

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & Flat St.
(c) Hospital or institution:
U.S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 40 days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Somerset
(c) City or town Crisfield
(If outside city or town limits, write RURAL and give town)
(d) Street No. 233 Somerset Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Somers, Alex Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Margaret Todd Somers
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 18, 1880

8. AGE: Years	Months	Days	If less than one day
65	10	26	hr. min.

9. Birthplace Deals Island, Md.
(Town, county, and state)
10. Usual Occupation mate
11. Industry or business seafaring

FATHER
12. Name Augustus Somers
13. Birthplace ?

MOTHER
14. Maiden Name Mary Benton
15. Birthplace Md.

16 (a) Informant Records
(b) Address US Marine Hospital, Balto, Md.

17 (a) Burial (b) Date thereof Dec. 17 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Crisfield, Md.

18 (a) Funeral director Bradshaw Funeral Home
(b) Address Crisfield, Md

DEC 14 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 13 1945, at 7:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 5 1945, to Dec. 13 1945, and that I last saw him alive on Dec. 13 1945.

Immediate cause of death Carcinoma, type unknown, of right lung — Duration Unknown

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon
Address Clinical Director US Marine Hospital, Balto, Md. Date signed 12/14/45

VS 150

G35120

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 33a

Registered No. G35120

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 517 Brune St.
(c) Hospital or institution: 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 50 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 517 Brune Street
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Bertha Robinson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex fem

5. Color or race col

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Andrew Robinson

6 (c) If alive, give age 58 years

7. Birth-date of deceased (mo., day, yr.) Oct. 9, 1895.

8. AGE: Years 50 | Months 6 | Days 25 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Basel Robinson
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Nancy Kemp
15. Birthplace Baltimore Md

16 (a) Informant Alfred Harris
(b) Address 517 Brune Street

17 (a) Burial (b) Date thereof 12-15-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 DEC 14 1945 (b) Huntingdon Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 12th 1945, at 3:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 6th 1945, to Dec 12 1945, and that I last saw her alive on Dec 10, 1945.

Immediate cause of death La Grippe followed by Bronchopneumonia. — Duration about 10 days.

Due to La Grippe

Due to exposure & cold

Other Conditions Became unable to swallow; weakened:
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. B. Toland, M.D.
M. D.

Address 426 N. Greene St. Date signed 12-13-45

VS 8

X

Information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

635121 WRIGHT ✓ 635121

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 635121

p3a

Please write the causes of death clearly and legibly. The correct age is especially important. Physicians: please write carefully supplied. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 16

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2.00
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 905 Pennsylvania Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julia Wright

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Col.	

6 (b) Name of husband or wife Fred Wright
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1880

8. AGE: Years	Months	Days	If less than one day
65	5		hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name Basil Owens
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Hannah Lewis
15. Birthplace Baltimore, Md.

16 (a) Informant Luther Owens
(b) Address 123 Winters Ave. Catonsville Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 17 1945 (month) (day) (year)
(c) Cemetery or crematory Western Star
Location Catonsville, Md.

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St

DEC (a) 1 1945 (Date rec'd by registrar) (b) for Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 10 1945, at 1:20 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

Autopsy, Inspection or Inquiry

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage, Hypertension

Due to

Other Conditions Ruptured Saccular aneurysm of basilar artery, Cerebellum Hemorrhage.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Masters M.D.
Medical Examiner.
Date signed 12-10-45

G35122

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G35122
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 506 N Arlington ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 d
(e) Length of stay in Baltimore (yrs., mos., or days) 17 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 506 N Arlington ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mamie Foulk
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex F
5. Color or race C
6 (a) Single, married, widowed, or divorced Widowed
6 (b) Name of husband or wife Geo. Foulk
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Jan 22, 1878
8. AGE: Years 67 Months 10 Days 19 If less than one day hr. min.
9. Birthplace Hagerstown Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Henry Kee
13. Birthplace St James Md

MOTHER
14. Maiden Name Ellen A Doose
15. Birthplace Sharpsburg Md

16 (a) Informant Mamie Foulk
(b) Address 506 N Arlington ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) Nov (day) 16 (year) '45
(c) Cemetery or crematory Rose Hill
Location Hagerstown Md.

18 (a) Funeral director Mrs. Katie R Williams
(b) Address 333 N. Schroeder St.

DEC 1 1945 (b) Hagerstown Md
(Date received by local registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-16 1945 at 6:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-20 1945 to 11-16 1945 and that I last saw h[illegible] alive on 11-10 1945.

Immediate cause of death Hypertension
Cardio Vascular Renal
Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations

of autopsy:

Duration
1 Yr.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Atwell Jones M. D.
Address 537 Dolphin St Date signed 11-16-45

G35123

BALTIMORE CITY HEALTH DEPARTMENT X ✓ 937

CERTIFICATE OF DEATH

Registered No. G35123

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. If correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) 14 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Annapolis
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ~~Ridgely P. Melvin~~ Ridgeley P. Melvin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Agusta Berwell Melvin ~~Mrs. Ridgely P. Melvin~~

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 4, 1881

8. AGE: Years	Months	Days	If less than one day
64	1	10	hr. min.

9. Birthplace Maryland, Denton (Town, county, and state)

10. Usual Occupation Judge of Court of Appeals

11. Industry or business of Maryland

FATHER
12. Name George T. Melvin
13. Birthplace Maryland

MOTHER
14. Maiden Name ? Elsie Hopkins
15. Birthplace Maryland

16 (a) Informant Mrs. Agusta Berwell Melvin
(b) Address Annapolis, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 17, 1945 (month) (day) (year)
(c) Cemetery or crematory Cedar Bluff Cemetery
Location Annapolis, Md.

18 (a) Funeral director Miles Lawrence
(b) Address 1005 N. Baltimore St.

19 DEC 14 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH December 14 1945; at 6.45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1945 to Dec. 14 1945 and that I last saw him alive on Dec 13 1945.

Immediate cause of death Coronary occlusion — Duration 7 days

Due to Arteriosclerotic heart disease

Due to

Other Conditions Uraemia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Frank Supplee, M.D.

Address Union Memorial Hospital Date signed 12-14-45

VS 150

G35124

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

117a

G35124

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution:
Univ of Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 Days.
(e) Length of stay in Baltimore (yrs., mos., or days) 70 Days.

2. USUAL RESIDENCE OF DECEASED:
(a) State Va. (b) County
(c) City or town Portsmouth
(If outside city or town limits, write RURAL and give town)
(d) Street No. 429 Mt. Vernon Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ~~William Brady~~ William Arthur Brady

3 (b) If veteran, name war

3 (c) Social Security Account No. 074-14-6881

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Sophie Brady ~~Dead~~

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 14, 1867

8. AGE: Years 78 | Months 5 | Days 0 | If less than one day hr. min.

9. Birthplace Patterson, N. J.
(Town, county, and state)

10. Usual Occupation Retired - Salesman

11. Industry or business

FATHER
12. Name Michael Brady
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Burns
15. Birthplace England

16 (a) Informant Mr. George E. Rogers
(b) Address 5913 Bateman Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 17, 1945 (month) (day) (year)
(c) Cemetery or crematory Olive Branch Cem,
Location Portsmouth, Va.

18 (a) Funeral director Wilbur L. Cumbo
(b) Address 4000 Liberty Heights Ave.

19 (a) Dec 17 1945 (Date rec'd by local registrar) (Registration District) Washington-Williams Md (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/14 1945, at 6 04 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11, 29 1945 to 12, 14 1945, and that I last saw him alive on 12, 14 1945

Immediate cause of death Probable pulmonary embolism

Due to Perforated Peptic ulcer

Due to Exhaustion

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 11/29 and 12/13

Major findings of operation: Perforation Peptic ulcer

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. Dorcas Clark M. D.
Address University Hosp. Date signed 12-14-45

VS 2

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

635125

Brennan
5217 Harford Road

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

635125
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6104 Birchwood Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6104 Birchwood Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John George Meinschein

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Wilhelmina
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 23, 1897

8. AGE: Years	Months	Days	If less than one day
48	5	18	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Bricklayer
11. Industry or business Own Business

FATHER
12. Name John G. Meinschein
13. Birthplace Germany

MOTHER
14. Maiden Name Louise Rannappe
15. Birthplace Maryland

16 (a) Informant Mrs. Wilhelmina Meinschein
(b) Address 6104 Birchwood Avenue-14

17 (a) Burial (b) Date thereof 12- -45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) DEC 14 1945 (b) Huntington Hilltop, Md.
(Date rec'd by Registrar) (Registration District No.)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 11, 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1945 to Dec 11 1945 and that I last saw h[illegible] alive on Dec 11 1945

Immediate cause of death Coronary Thrombosis — Duration

Due to Coronary artery disease Cardiac symptoms

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas Brennan M. D.
Address 5217 Harford Road Date signed 12-12-45

VS 150

X

G35126

J. S. Harding
4810 Belair Rd.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 935

Registered No. G35126

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4114 Wilke Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4704 Belair Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anna Wilke

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife William Wilke
6 (c) If alive, give age 82 years

7. Birth date of deceased (mo., day, yr.) Dec. 27, 1869

8. AGE: Years	Months	Days	If less than one day
75	11	14	hr. min.

9. Birthplace Holland (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name ? Kirkler
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mr. William Wilke
(b) Address 4704 Belair Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/14/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Bltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

DEC 14 1945 (Date received by registrar) (b) Huntington Pittsman, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 11, 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1945 to 12/11 1945. and that I last saw her alive on 12/10 1945.

Immediate cause of death: Ch myocarditis — Duration 1 Year

Due to Ch Hty pulmonary

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. S. Harding M. D.
Address 4810 Belair Rd Date signed 12/14/45

X

G35127

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 195E

G35127 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dos
(e) Length of stay in Baltimore (yrs., mos., or days) 2

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1445 Patapsco St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert Walker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Mary Walker

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/1/1895

8. AGE: Years 50 | Months 0 | Days 11 | If less than one day hr. min.

9. Birthplace Dacia. (Town, county, and state)

10. Usual Occupation Steward.

11. Industry or business B & O. R. R.

FATHER 12. Name Albert.

13. Birthplace Europe. BLIND

MOTHER 14. Maiden Name Julia Blue Ge

15. Birthplace Europe.

16 (a) Informant Family

(b) Address 1445 Patapsco St.

17 (a) D. (Burial, cremation, or removal) (b) Date thereof 12-17-45 (month) (day) (year)

(c) Cemetery or crematory Cedar Hill

Location Dundalk Md

18 (a) Funeral director J. H. Tenney

(b) Address 6 E. Fayette St.

DEC 14 1945 (Date rec'd by registrar) Huntington Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 12 1945, at 2:15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fracture of sternum
Fracture of ribs
Rupture of inferior vena cava

Other Conditions Hemorrhage left chest.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-12-45 about 2:15 P.M.
(b) Where did injury occur? Locust Point
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury Struck by falling object

23. Signature Benedict Ostarelle M.D.
Medical Examiner.
Date signed 12-12-45.

G35128

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a ✓

Registered No. G35128

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3320 Spaulding Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 - 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3320 Spaulding Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Lena L. Slack

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Harry W. Slack
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 12 1896

8. AGE: Years	Months	Days	If less than one day
49	10	1	hr. min.

9. Birthplace Carroll Co. Maryland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name Phillip Lee
13. Birthplace Carroll Co. Maryland

MOTHER
14. Maiden Name Estherne L. Buckingham
15. Birthplace Carroll Co. Md.

16 (a) Informant Harry W. Slack
(b) Address 3320 Spaulding Ave

17 (a) Burial (b) Date thereof 12-15-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location Baltimore, Md.

18 (a) Funeral director Loring Byrne
(b) Address 5005 Park Heights Ave

19 DEC 14 1945 (b) Hunter for Baltimore, Md.
(Signature of registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 13, 1945, at 5:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/5 1945 to 12/13 1945, and that I last saw h[illegible] alive on 12/13 1945.

Immediate cause of death Duodenal carcinoma
Metastasis

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry Russell
Address 3902 Gwynn Oak Ave. Date signed 12/13/45

Henry Russell M.D. X

G35129

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G35129

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) Died
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. Ambassador Apts
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nancie C. Jenkins

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. ✓

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife John J. Jenkins

6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.) June 22 1880

8. AGE: Years 65 | Months 5 | Days 22 | If less than one day ..... hr. ..... min.

9. Birthplace md.
(Town, county, and state)

10. Usual Occupation Home duties

11. Industry or business

FATHER
12. Name Dr. Chas. Combs
13. Birthplace md.

MOTHER
14. Maiden Name Rosa Stone
15. Birthplace md.

16 (a) Informant John J. Jenkins
(b) Address Ambassador apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 14 45 (month) (day) (year)

(c) Cemetery or crematory New Cathedral
Location Edmondson Ave

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 1900 Eutaw Place

DEC 14 1945 (Date received by Registrar)

(b) Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/13 1945, at 3.45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection-Investigation (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Cerebral Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Jakubowski M.D.
Medical Examiner.
Date signed 12/13/45

X

G35130

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G35130

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: John Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Pikesville - Essex Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 147 Riverside Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Casper Krause

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Theresa nee Dexter

6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) Feb. 9 - 1872

8. AGE: Years	Months	Days	If less than one day
73	10	3	hr. min.

9. Birthplace Hungary (Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business Retired

FATHER
12. Name Casper Krause
13. Birthplace Hungary

MOTHER
14. Maiden Name Unknown
15. Birthplace Hungary

16 (a) Informant Mrs. Theresa Krause
(b) Address 147 Riverside Rd.

17 (a) Burial (b) Date thereof Dec. 18-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave. Blvd.

18 (a) Funeral director John J. Connolly
(b) Address 416 Eastern Ave Essex

19 (a) Date received (by Registrar) DEC 14 1945 (b) Registrar Huntington Williams

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/12 1945, at 3:45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection-Inquest thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature T. J. Lubowski M.D.
Medical Examiner.
Date signed 12/13/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35131 HEALTH DEPARTMENT—CITY OF BALTIMORE G35131

CERTIFICATE OF DEATH

X 1092

1. PLACE OF DEATH Volunteers of Amer. Hospt. Registered No.

CITY OF BALTIMORE: (No. 4200 Lexington St. St., Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos 13 ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Rose Ann Stoops If U. S. Veteran specify WAR.

(a) Residence: No. 8 Wagner's Lane, Essex St., Ward. Baltimore
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
F	W	

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, year) Dec. 1, 1945

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
		13	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Beeto (State or country) Md

FATHER

13. NAME Wallin Bailey

14. BIRTHPLACE (city or town) (State or country) Kentucky

MOTHER

15. MAIDEN NAME Josephine Stoops

16. BIRTHPLACE (city or town) Middletown (State or country) Ohio

17. INFORMANT (Address)

18. BURIAL, CREMATION, OR REMOVAL Place Sacred Heart Date Dec. 15 1945

19. UNDERTAKER John L. Connelly (Address) Essex, Md.

20. DEC 14 1945 19 Registrar Huntington Hill

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Dec. 14, 1945

22. I HEREBY CERTIFY, That I attended deceased from Dec. 1, 1945 to Dec. 14 1945

I last saw h[illegible] alive on Dec 13, 1945. Death is said to have occurred on the date stated above, at 8.30 a.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Virus pneumonia	Dec 8th

Other contributory causes of importance:

Was an operation performed? Date of

For what disease or injury?

Name of operation

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? Date of injury 19

Where did injury occur?
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify.

(Signed) Reinhard Epps M. D.

(Address) Volunteers of American Hosp.

X

SEE CAUSE OF DEATH in plain terms. [illegible] OCCUPATION is very important. See instructions on back of certificate.

G35132

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G35132

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: University Hospital 20
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-0-A
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2541 Ashton Street
(If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME John A. Bode

3 (b) If veteran, name war: Spanish American

3 (c) Social Security Account No. 212-09-3620

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Gertrude, M.

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 12. JAN. 1884

8. AGE: Years 61-6 | Months 11 | Days — | If less than one day — hr. — min.

9. Birthplace Baltimore - Maryland
(Town, county, and state)

10. Usual Occupation BUSINESS - Agent.

11. Industry or business Local 101 - Carpenters Union

FATHER
12. Name John Bode
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary ?
15. Birthplace Maryland

16 (a) Informant Wife Mrs. Gertrude M. Bode
(b) Address 2541 Ashton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 15-Dec. 45- (month) (day) (year)
(c) Cemetery or ~~cemetery~~ Holy Redeemer
Location Belair Rd. Balto. Md

18 (a) Funeral director C. B. Muppert & Son
(b) Address 120 Eutaw Place -

DEC 14 1945
(Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-12- 1945, at 12 30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection of Injuries thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed 12-12-45-

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35133 HEALTH DEPARTMENT—CITY OF BALTIMORE G35133

CERTIFICATE OF DEATH

1109a

1. PLACE OF DEATH Bal. of Women's Hosp. Registered No.

CITY OF BALTIMORE: (No. 418 W Lexington St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ... yrs. ... mos. ... da. How long in U. S. If of foreign birth? ... yrs. ... mos. ... da.

2. FULL NAME Dorothy Jean Smith If U. S. Veteran specify WAR

(a) Residence: No. 1327 W. Baltimore St. 19-3 Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
F	W	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, year) Nov. 26, 1945

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		16 17	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) BALTO (State or country) MD.

FATHER

13. NAME MARTIN SMITH

14. BIRTHPLACE (city or town) Pineville (State or country) Ky.

MOTHER

15. MAIDEN NAME Vernice Sizemore

16. BIRTHPLACE (city or town) Barbourville (State or country) Ky.

17. INFORMANT Vernice Smith
(Address) 1327 W. Balto St.

18. BURIAL, CREMATION, OR REMOVAL
Place University Medical School DEC 14 1945

19. UNDERTAKER Commissioner of Health
(Address)

20. FILED DEC 14 1945 Hunter for Williams M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Dec. 12, 1945

22. I HEREBY CERTIFY, That I attended deceased from Nov. 26, 1945 to Dec. 12 1945

I last saw her alive on Dec. 11, 1945. Death is said to have occurred on the date stated above, at 2:30 a.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Lobar pneumonia	Dec 7

Other contributory causes of importance:

Was an operation performed? ... Date of ...

For what disease or injury? ...

Name of operation ...

What test confirmed diagnosis? ... Was there an autopsy? ...

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ... Date of injury ... 19...

Where did injury occur? ...
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place ...

Manner of injury ...

Nature of injury ...

24. Was disease or injury in any way related to occupation of deceased?
... If so, specify ...

(Signed) Leonard Gaspe M. D.

(Address) Volunteers of America Hospital

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

F 3141 X

G35134

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1159

G35134 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Sparrow Point
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1026 H 5th
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Cosser

3 (b) If veteran, name war:

3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/6/45

8. AGE: Years 0 | Months | Days 0 | If less than one day 20 hr. min.

9. Birthplace Baltimore County
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ??
13. Birthplace

MOTHER
14. Maiden Name Clara Cosser
15. Birthplace Maryland

16 (a) Informant Clara Cosser
(b) Address 1026 H St Sparrow Pt

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School DEC 14 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 DEC 14 1945 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 7 1945, at 5:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-6 1945, to 12-7 1945 and that I last saw her alive on 12-7 1945.

Immediate cause of death	Duration
Atelectasis	
Due to Prematurity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. W. Baggett M. D.
Address University Hosp. Date signed 12/14/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 3

3140

X

G35135

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170c

G35135 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 522 N. Glover Street (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Albert WIEGAND Wiegand

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Elizabeth Kramer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 27, 1890

8. AGE: Years: 55 yrs. | Months: 2 | Days: 14 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business: School Board

FATHER
12. Name: Unknown
13. Birthplace: "

MOTHER
14. Maiden Name: "
15. Birthplace: "

16 (a) Informant: Mrs. Elizabeth Wiegand
(b) Address: 522 N. Glover Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/15/45 (month) (day) (year)
(c) Cemetery or ~~Crematory~~: Holy Redeemer
Location: Belair Rd. Baltimore, Md.

18 (a) Funeral director: Charles E. Schimunek
(b) Address: 2601 E. Madison Street

19 (a) DEC 14 1945 (b) [illegible] for Hiss

MEDICAL CERTIFICATION 35

20. DATE OF DEATH December 11, 1945 at 10 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH: Skull fracture
Due to: Intracranial hemorrhage
Other Conditions:
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 6/2
(a) Date of injury 12-11-45 at 6 P. M.
(b) Where did injury occur? Balto. Ave. & Lakewood Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury: Pedestrian struck by auto

23. Signature: Benedict Stetardi M.D. Medical Examiner.
Date signed 12-12-45

VS 151

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35136

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

G35136 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1507 Elmtree St. Curtis Bay.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1507 Elmtree St. Curtis Bay. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Frances Ann Fried

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1, 1900

8. AGE: Years	Months	Days	If less than one day
45	9	10	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Nurse
11. Industry or business

FATHER
12. Name Frank Fried
13. Birthplace Czechoslovakia

MOTHER
14. Maiden Name Anna Baburek
15. Birthplace Czechoslovakia

16 (a) Informant Mrs. Anna Fried (mother)
(b) Address 1507 Elmtree St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/15/45 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Holy Cross
Location Annapolis Blvd. Baltc. Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street

19 (a) 1-4 1945 (Date received by registrar) (b) Huntington Willi (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 11 1945 ~~12:45~~ M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 6 1945, to Dec 11 1945, and that I last saw h~~e~~r alive on Dec. 10 1945.

Immediate cause of death	Duration
Metastatic Carcinoma of liver	3 weeks.
Due to Carcinoma of breast	1 year
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation January 1945

Major findings of operation: Carcinoma of breast, axillary glands

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature P. J. Gennaldi M. D.
Address 4609 Gor. Ritchie Hwy. Date signed 12-13-45

X

G35137

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G35137

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mount Hope Retreat
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 days
(e) Length of stay in Baltimore (yrs., mos., or days) 23 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Virginia (b) County
(c) City or town Dahlgren
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clark Roby

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1880

8. AGE: Years	Months	Days	If less than one day
65	6		hr. min.

9. Birthplace Charles County Maryland (Town, county, and state)

10. Usual Occupation Government Printer

11. Industry or business

FATHER
12. Name Isiah Roby
13. Birthplace Charles County Maryland

MOTHER
14. Maiden Name Ida Cox
15. Birthplace Charles County Maryland

16 (a) Informant Mount Hope Retreat
(b) Address 6420 Reisterstown Rd. Balto. Md.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 12/14/45 (month) (day) (year)
(c) Cemetery or crematory
Location Tompkins, Maryland

18 (a) Funeral director James J. Ryan Inc.
(b) Address 317 Park Ave

19 DEC 14 1945 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH December 14 1945, at 11:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from November 21 1945, to December 14 1945, and that I last saw him alive on December 14 1945.

Immediate cause of death: Myocardial Infarcts — Duration: 23 days

Due to

Due to

Other Conditions: General Arteriosclerosis Involutional Melancholia 1½ Mo. (Include pregnancy within 3 months of death) — Duration: ?

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. P. Abyea M. D.
Address 336 Park Ave Date signed

635138

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 635138

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to correct are is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun
(c) Hospital or institution: Franklin Square
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Pikesville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1703 Reisterstown Road
(If rural give location)
(e) Citizen of foreign country? ---- (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur George Young

3 (b) If veteran, name war: -----

3 (c) Social Security Account No. 217-09-2651

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Anna

6 (c) If alive, give age 40 ~~1905~~

7. Birth date of deceased (mo., day, yr.) April 9, ~~1906~~

8. AGE: Years	Months	Days	If less than one day
~~35~~ 35	8	4	hr. ____ min.

9. Birthplace New York N.Y. (town, county, and state)

10. Usual Occupation Filling Station Attendant

11. Industry or business Sherwood Bros. Inc.

FATHER
12. Name George Young
13. Birthplace Unknown

MOTHER
14. Maiden Name Effie Young ?
15. Birthplace Unknown

16 (a) Informant Mrs. Anna Morris Young
(b) Address Pikesville, Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 16, 1945 (month) (day) (year)
(c) Cemetery or crematory Sater's Cemetery
Location Brooklandville, Maryland

18 (a) Funeral director John Burns & Sons
(b) Address Towson, Maryland

DEC 15 1945 Huntington Williams M.D. (Local Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-13 1945, at 4:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-15 1945 to 12-13 1945 and that I last saw h~~im~~er alive on 12-13 1945.

Immediate cause of death	Duration
acute Cardiac failure	
Due to Arteriosclerotic Cardiovascular disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 12-13-45

Major findings of operation: Mitral stricture Dyspnoea Cyanosis

of autopsy: Pulmonary congestion

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. K. Kenyon M.D.
Address Franklin Sq. Hospital Date signed 12-15-45

(Over) X arteriosclerosis of small patchy heart

635139 BEBNOWSKI

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 635139

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 35. N. Belnord Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 500 S. Luzern Ave/ (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Bebnowski

3 (b) If veteran, name war
3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Frances
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 30/1887

8. AGE: Years	Months	Days	If less than one day
57	3	13	hr. min.

58

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Teofil Bebnowski
13. Birthplace Poland

MOTHER
14. Maiden Name Unk
15. Birthplace Poland

16 (a) Informant Frances Bebnowski
(b) Address 500 S. Luzern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 17/45 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Fred W. Ozarowski
(b) Address 1930 Eastern Ave.

DEC 15 1945

(Date received by registrar) Huntington Hills Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 12 1945, at 7.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/1/44 19 to 12/12 1945 and that I last saw him alive on 12/12/45 19

Immediate cause of death Coronary Thrombosis — Duration 12/10 45

Due to Chr Myocarditis — 3/1/44

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William J Rosack M.D.
Address 601 N. Kenwood Ave Date signed 12/14/45

635140

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 B

Registered No. 635140

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Give full data relative to the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 322 S. Williams St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sophie Janowski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: [redacted] Janowski

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-14-04

8. AGE: Years	Months	Days	If less than one day
41	10	29	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Peter Lukoski
13. Birthplace Poland

MOTHER
14. Maiden Name ? ?
15. Birthplace ?

16 (a) Informant JOSEPH JANOWSKI

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof DEC. 17/45 (month) (day) (year)

(c) Cemetery or crematory Holy Rosary

Location Baltimore

18 (a) Funeral director Fred W. Ozarowski

(b) Address 1980 Eastern Ave.

19 (a) [illegible] 1945 (b) Huntington Ave. (Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-13 1945, at 12:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-26 1945, to 12-13 1945, and that I last saw h[illegible] alive on 12-13 1945

Immediate cause of death	Duration
Pulmonary tuberculosis	
Due to	
Due to	
Other Conditions Diabetes Mellitus	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John L. Green, M.D.

Address Johns Hopkins Date signed 12/13/45

X

HEALTH DEPARTMENT—CITY OF BALTIMORE

G35141 CERTIFICATE OF DEATH ✓ 477 G35141

1. PLACE OF DEATH 1438 Hanbert St.

CITY OF BALTIMORE: (No. 1438 St., Ward)

Registered No.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME John Greiner

If U. S. Veteran specify WAR

(a) Residence: No. 1438 Hanbert St. St., 24-1 Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Myrtle Greiner

6. DATE OF BIRTH (month, day, year) August 1, 1897

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
48	4	13 11	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Policeman

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Balto Police dept

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Balto, Md.

FATHER

13. NAME Martin Greiner

14. BIRTHPLACE (city or town) (State or country) Germany

MOTHER

15. MAIDEN NAME Theresa Katz

16. BIRTHPLACE (city or town) (State or country) Baltimore

17. INFORMANT Mrs. Myrtle Greiner
(Address) 1438 Hanbert St.

18. BURIAL, CREMATION, OR REMOVAL
Place Cedar Hill Date 12-15 19 45

19. UNDERTAKER Chas. F. Dill
(Address) 1501 E. Fort Ave.

20. FILED 19
Registrar.

DEC 15 1945

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) 12-12 , 1945

22. I HEREBY CERTIFY, That I attended deceased from Jan. 2, 1945 to Dec. 12, 1945

I last saw him alive on 12-12, 1945 Death is said to have occurred on the date stated above, at 10:20 a.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Carcinoma of Lung	1-2-45
Other contributory causes of importance	

Was an operation performed? Date of

For what disease or injury?

Name of operation Biopsy

What test confirmed diagnosis? Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur?
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) A. Gallod M. D.

(Address) 707 E. Fort Ave

SAME CAUSE OF DEATH in plain terms, no abbreviations. Exact OCCUPATION is very important. See instructions on back of certificate.

G35142

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G35142 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 5-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 213 Calvin Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Georgia Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Henry A. Williams

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 14th 1893

8. AGE: Years 50 | Months S.T. 1 | Days 1 | If less than one day hr. min.

9. Birthplace Washington N. C.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Martha ?
15. Birthplace Unknown

16 (a) Informant Joshua Gittings
(b) Address 213 Calvin St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-15-45 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary
Location Balto. Co. Md.

18 (a) Funeral director Babcock & Mangum & Hughes
(b) Address 721 Druid St

19 (a) (Date received by registrar) (b) Huntington Williams, M.D. Registrar

DEC 15 1945

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 11, 1945, at 8 P. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Dec. 12 1945

correct age is especially important. Physicians: please write the causes of death clearly and legibly. The

G35143
JL - 96768

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH √83B

Registered No. G35143

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 - 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1413 N. Bruce St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Adelaide Lake

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Sep.

6 (b) Name of husband or wife: Edward Lake
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. ? 1898

8. AGE: Years	Months	Days	If less than one day
47	2 ?	?	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name May Cedric
15. Birthplace ?

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/17/45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Reg. A. Kelso
(b) Address 1303 Presstman St

19 (a) Dec 19 1945 (Date received by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 9, 1945 19 , at 10pm M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 19 1945 to Dec. 9 1945, and that I last saw her alive on Dec. 9, 1945.

Immediate cause of death	Duration
Cerebral Thrombosis	7
Due to arteriosclerosis	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: none
of autopsy: not reported yet

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature T. P. Jernigan M. D.
Address Baltimore City Hosp. Date signed 12-13-45

G35144

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G35144

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sydenham Hosp.
(c) Hospital or institution
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 da
(e) Length of stay in Baltimore (yrs., mos., or days) 17 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1625 McCulloh (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Agnes Cecilia Dyson
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 11, 1928

8. AGE: Years 17 | Months 6 | Days 3 | If less than one day ____hr. ____min.

9. Birthplace Baltimore City (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name Moses Dorsey
13. Birthplace Galveston Texas

MOTHER
14. Maiden Name Rachel Dyson
15. Birthplace St Mary's Co, Md.

16 (a) Informant Rachel Dyson Barrington
(b) Address 1628 McCulloh St

17 (a) Removal (b) Date thereof Dec 14, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St Peters
Location Md

18 (a) Funeral director Geo. H. Kelson
(b) Address 1303 Pennsylvania Ave.

19 (a) Date rec'd by local reg. Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 13, 1945 at 1:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 9 1945 to Dec 13 1945 and that I last saw h[illegible] alive on Dec 13 1945

Immediate cause of death Meningitis — Duration 9 days

Due to Tuberculosis — Duration ? yrs

Due to — Duration

Other Conditions Bronchopneumonia — Duration 5 days

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: The Meningitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Metchijah Sprague M. D.
Address Sydenham Hosp. Date signed 12-14-45

VS 150

write the causes of death clearly and legibly. Physicians: please write as completely as possible. Typewriter is especially important.

G35145

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170 C

G35145

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State D.C. (b) County
(c) City or town Washington
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1120 Owen Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SHIRLEY FRANCIS ~~OYHUER~~ Mayhugh

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/19/1919

8. AGE: Years	Months	Days	If less than one day
26 25	—	26	hr. min.

9. Birthplace Wash. D. C.
(Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business

FATHER
12. Name Frank C. Mayhugh
13. Birthplace Sterling, Va.

MOTHER
14. Maiden Name Jessie L. Yowell
15. Birthplace Culpepper, Va.

16 (a) Informant Mrs. Jessie Mayhugh (Mother)
(b) Address

17 (a) Removal (b) Date thereof 12/15/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Removal to Wash.
Location

18 (a) Funeral director J.W. Lee & Son's Co.
(b) Address Washington, D.C.

19 (a) (b) Huntington Wash. Registrar
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 15, 1945, at 2:45 A. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured Skull

Due to

Other Conditions Fractured clavicle, scapula, ribs, & humerus etc.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-15-45 at 2:10 A. M.
(b) Where did injury occur? Balto.-Wash. Blvd. 300' south of Pa. R.R. bridge, Balto. Co.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Auto. & Truck collision

23. Signature Howard J. Medeiros M.D.
Medical Examiner.
Date signed 12-15-45

635146

HD # 15410

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

635146

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully... correct age is especially important. Physicians: please write the...

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 5 1
(e) Length of stay in Baltimore (yrs., mos., or days) 80 4 10

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2314 W. Fayette St.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME William H. Turner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife Ella Turner

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 3, 1865

8. AGE: Years	Months	Days	If less than one day
80	4	10	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation carpenter

11. Industry or business Retired

FATHER
12. Name Walter Ball Turner
13. Birthplace Maryland

MOTHER
14. Maiden Name Emily Turner Lowther
15. Birthplace Maryland

16 (a) Informant Balto. City Hospitals Records
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-15-45 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Maryland

18 (a) Funeral director George L. Ashworth
(b) Address 2101 Frederick Avenue

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 13, 1945, at 4:25P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 12, 1926, to Dec. 13, 1945, and that I last saw him alive on Dec. 13, 1945.

Immediate cause of death Bronchopneumonia — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: none

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature T. P. Jennings M. D.

Address Baltimore City Hosp. Date signed 12-14-45

X

Blackert

G35147

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

164a

Registered No. G35147

write the causes of death clearly and legibly. Physicians: please write as especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address or Hospital or Institution: Baltimore Maryland Franklin Square Hospital. 20-6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 d. 0 hr.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 524 S. Longwood Ave. (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME William Joseph Blackert

3 (b) If veteran, name war: None
3 (c) Social Security Account No. 213-05-3037
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.): February 2, 1900
8. AGE: Years 45 | Months 10 | Days 12 | If less than one day ... hr. ... min.
9. Birthplace: Baltimore Md. (Town, county, and state)
10. Usual Occupation: Brushmaker
11. Industry or business: Pittsburgh Plate Glass
FATHER 12. Name: George H. Blackert
13. Birthplace: Germany
MOTHER 14. Maiden Name: Anna J. Kapraun
15. Birthplace: Maryland
16 (a) Informant: Joseph H. Blackert
(b) Address: 2728 Georgetown Road
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-17-45 (month) (day) (year)
(c) Cemetery or crematory: New Cathedral
Location: Baltimore - Md.
18 (a) Funeral director: George L. Schnorf
(b) Address: 2101 Eldorado Ave.
19 (a) ... (Date rec'd by registrar) (b) ... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 14, 1945, at 6:30 P.M.

21. I certify that I took charge of the remains described above, held an inquest and inquiry thereon and from the evidence obtained Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Asphyxiation due to hanging.
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-14-45 at 4 P.M.
(b) Where did injury occur? 524 S. Longwood Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No.
(d) Means of injury: found hanging by rope fastened

23. Signature: Benedict Stathurelis M.D. Medical Examiner.
Date signed: December 15, 1945

VS 151

Huntington Williams M.D.

X

G35148

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 51B

G35148
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood + Greene Sts.
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md' (b) County Balto Co -
(c) City or town 2809 Linwood Ave.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Parkville,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maempel, Louis P. MAEMPEL

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: none

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mary E. Maempel

6 (c) If alive, give age: 68 years

7. Birth date of deceased (mo., day, yr.): June 19, 1863

8. AGE: Years: 82 | Months: 5 | Days: 24 | If less than one day: hr. min.

9. Birthplace: Balto. Md
(Town, county, and state)

10. Usual Occupation: Retired

11. Industry or business

FATHER
12. Name: Charles F. Maempel
13. Birthplace: Germany

MOTHER
14. Maiden Name: Amelia Rosmodel
15. Birthplace: Germany

16 (a) Informant: Mary E. Maempel
(b) Address: 2809 Linwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Dec 17, 1945 (month) (day) (year)
(c) Cemetery or crematory: London Park
Location: City

18 (a) Funeral director: Wm. Mrs. John W. Teufel & Son
(b) Address: 801 W. Lafayette St.

19 DEC 15 1945 (b) Registrar
(Date received by Local Registrar)
Huntington Williams, M.D.

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12-13 1945, at 7:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/9 1945 to 12/13 1945, and that I last saw h.l.w. alive on 12/13 1945

Immediate cause of death	Duration
Coronary Thrombosis	1 day
Due to Hardened Arteries -	
Due to	
Other Conditions Carcinoma of the Prostate gland. (Include pregnancy within 3 months of death)	

Date of operation: 12/11/45

Major findings of operation: Carcinoma of Prostate gland

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Melvin A. Johnson

Address: University Hospital Date signed: M. 12 D. 13 '45

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

635149

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 635149 / 108

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: South Baltimore Gen'l.
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dea
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1820 Beet St. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME John Laurence Williams

3 (b) If veteran, name war	3 (c) Social Security Account No.
	-

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife.....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 9/17/45

8. AGE: Years	Months	Days	If less than one day
	3 2	2 6	.....hr. .....min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Edward J Williams
11. Industry or business

FATHER
12. Name Edward J Williams
13. Birthplace Rosemont, Md -

MOTHER
14. Maiden Name Ruth Va. Thomas
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Ruth Williams
(b) Address 1820 Beet St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/17/45 (month) (day) (year)
(c) Cemetery or crematory Western Cem
Location 3000 Edmondson Ave

18 (a) Funeral director John F Henry Inc
(b) Address 745 Eight St.

DEC 15 1945
(Date rec'd by Registrar) Hattie Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 - 13 - 1945, at 1 24 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute interstitial pneumonia.

Due to.....

Other Conditions Mal nutrition

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at ..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Robert Lee Embrey M.D.
Medical Examiner.
Date signed 12/13/45

G35150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48 B

Registered No. G35150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered and correct answer given. Physicians: please write the causes of death clearly and legibly. Underline the cause to which death should be charged statistically.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 428 N. Eugenia Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 428 N. Eugenia Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Hazel A. Schissler

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-10-7907

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Joseph A. Schissler

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 8 1902

8. AGE: Years 43 | Months 4 | Days 5 | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Press operator

11. Industry or business Eastern Stamping Co

FATHER 12. Name William G. Reining

13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Unknown

15. Birthplace "

16 (a) Informant Elizabeth M. Schissler

(b) Address 428 N. Eugenia Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-17-45 (month) (day) (year)

(c) Cemetery or crematory Balto. Cemetery

Location North Ave

18 (a) Funeral director John E. Miller

(b) Address 2435 Huntington Ave, Balto, Md

19 (a) Filed DEC 15 1945 (Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-13 1945 at 8 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 22 1944 to Dec. 13 1945 and that I last saw h... alive on 19

Immediate cause of death	Duration
metastatic carcinoma	1½ yrs.
Due to carcinoma uterus	1½ yr.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation Sept. 16 1944

Major findings of operation: carcinoma uterus

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature S. A. Alessi M. D.

Address 6217 Harford Rd Date signed

VS 150

X

G35151
483935

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 30 P

Registered No. G35151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 606 Somerset St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edward Jackson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Naomi
6 (c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr.) 4-20-84

8. AGE: Years 61 | Months 7 | Days 23 | If less than one day ____ hr. ____ min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Rubber

11. Industry or business

FATHER
12. Name David Jackson
13. Birthplace 2.

MOTHER
14. Maiden Name Betty 2.
15. Birthplace

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 17, 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Baltimore
18 (a) Funeral director Robert L. Emerick
(b) Address 604 N. Carrollton Ave.
19 (a) Date received DEC 15 1945 Huntington Hollins, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 13 1945, at 2.15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 19 1945 to Dec. 13 1945 and that I last saw him alive on Dec. 13 1945.

Immediate cause of death	Duration
? Coronary Occlusion	
Due to: ? Arteriosclerosis ? Coronary arteritis	
Due to: ? Syphilitic Aortitis	
Other Conditions Acute Bronchitis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas A. Stephenson M.D.
Address Johns Hopkins Hosp. Date signed 12/13/45

VS 150

G35152

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G35152

Every item of information should be carefully supplied, WITH UNFADING INK. Be sure that correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3811 Northern Parkway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 5
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3811 Northern Parkway
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME FRANK A. SWEGON

3 (b) If veteran, name war	3 (c) Social Security Account No.
World War I	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Teresa
6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) January 3, 1893

8. AGE: Years	Months	Days	If less than one day
52	11	9	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Martin Swegon
13. Birthplace Poland

MOTHER
14. Maiden Name Anna Dziennik
15. Birthplace Poland

16 (a) Informant Mrs. Teresa Swegon
(b) Address 3811 Northern Parkway

17 (a) Burial (b) Date thereof 12/17/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director M. F. Sadowski & Son
(b) Address 1808 Eastern Avenue

19 DEC 15 1945 (b) Huntingtown Williamsport MD
Date received by Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-12- 1945, at 10:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-8- 1945 to 12-12- 1945 and that I last saw him alive on 12-12- 1945.

Immediate cause of death	Duration
Coronary Thrombosis	5 hrs.
Due to Generalised arterio-sclerosis and hyper-tension	?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature Melvin C. Laney M. D.
Address 2117 Belair Rd Date signed 12-15-45

VS 150

X

635153
48522

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

152 B

Registered No. 635153

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va. (b) County
(c) City or town Pender Co. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3rd Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: Dr. Commodore M Kimble

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male.	White.	married

6 (b) Name of husband or wife Bertha
6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) 4-16-82

8. AGE: Years	Months	Days	If less than one day
63	7	28	hr. min.

9. Birthplace W. Va. (Town, county, and state)
10. Usual Occupation Physician
11. Industry or business

FATHER
12. Name Uriah Kimble
13. Birthplace W. Va

MOTHER
14. Maiden Name Florida Buck
15. Birthplace W. Va.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/18/45 (month) (day) (year)
(c) Cemetery or crematory Northview
Location New Martinsville, W. Va.

18 (a) Funeral director John D. Mitchell & Son. Inc.
(b) Address 1900 Eutaw Place

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 14 1945 at 7.23 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 12. 1945 to Dec. 14 1945, and that I last saw him alive on Dec. 14 1945.

Immediate cause of death	Duration
Hypostatic pneumonia	
Due to Peritonitis following ureters-sigmoid anastomosis	
Due to Carcinoma of bladder	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Herbert A Borchow M. D.
Address Johns Hopkins Hosp. Date signed 12/17/45

VS 150

635154

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a ✓

Registered No. 635154

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Wyman Pk. Drive & 31st St.
(c) Hospital or institution: U.S. Marine Hospital, Balto, Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) 18 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Marley Neck Road Glen Burnie
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Nielsen, Blanche Scott

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Carl Nielsen
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Jan. 1, 1884

8. AGE: Years 61 | Months 11 | Days 13 | If less than one day ____ hr. ____ min.

9. Birthplace: Sinks Grove, W.Va. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Cornelius Scott
13. Birthplace: W.Va.

MOTHER
14. Maiden Name: Betty Carroway
15. Birthplace: W.Va.

16 (a) Informant: Records
(b) Address: US Marine Hospital, Balto, Md.

17 (a) Burial ✓ (Burial, cremation, or removal) (b) Date thereof 12/15/45 (month) (day) (year)
(c) Cemetery or crematory: SINK GROVE
Location: WEST VIRGINIA

18 (a) Funeral director: William [illegible] Son
(b) Address: 521 St Paul St
(Funeral director or [illegible])

19 (a) DEC 19 1945 (Date rec'd by registrar) (b) ____ Registrar

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 14 1945, at 3:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 3 1945, to Dec. 14 1945, and that I last saw h[illegible] alive on Dec. 14 1945.

Immediate cause of death: Cerebral hemorrhage, right side — Duration: 2 wks

Due to: Arteriosclerosis, general
Due to: Cerebral arteriosclerosis
Due to: Hypertension

Other Conditions: Senile cataract left eye
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy: Not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address: Clinical Director Date signed 12/15/45
US Marine Hospital, Balto, Md.

635155 BALTIMORE CITY HEALTH DEPARTMENT 635155

CERTIFICATE OF DEATH 61

Registered No.

Please write plainly, with unfading ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1416 Longwood St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1415 Longwood St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helen Imhoff.

3 (b) If veteran, name War | **3 (c) Social Security Account No.**

4. Sex Female | **5. Color or race** White | **6 (a) Single, married, widowed, or divorced.** Widowed

6 (b) Name of husband or wife John Imhoff
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 5 — 1870

8. AGE: Years 75. | Months 9. | Days 8. | If less than one day hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation Home Duties

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Germany.

MOTHER
14. Maiden Name Helen Gluck.
15. Birthplace Germany.

16 (a) Informant Mr. William Imhoff
(b) Address 605 Dukeland St.

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** Dec 17 1945 (month) (day) (year)

(c) Cemetery or crematory Meadow Ridge Mem.
Location Elkridge Md.

18 (a) Funeral director Francis B. Byrer
(b) Address 1600 W. North Ave

19 (a) DEC 6 1945 **(b)** (Date received by Registrar) Wm. Wilson, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 13 1945; at 12-30M

21. I certify that death occurred on the date above stated; that I attended deceased from July 20 1945 to Dec 13 1945. and that I last saw her alive on Dec 13 1945.

Immediate cause of death	Duration
Cardio-Vascular Renal Disease	
Diabetes Mellitus	
Due to	
Due to Uremia	
Cardiac Dilatation	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Vincent M. Mesoraca M. D.
Address 1403 S. Charles St Date signed 12/17/45

635156

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 635156

1. Every item of information should be carefully supplied. The space WRITE PLAINLY, WITH UNFADING INK. Be sure to write the causes of death clearly and legibly. Physicians: please write the exact age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
U.S. Marine Hospital, Balto, Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town Philadelphia
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1834 N. Segel St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Corini, Paul N. Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 6, 1915

8. AGE: Years	Months	Days	If less than one day
30	5	8	hr. min.

9. Birthplace Phila., Pa.
(Town, county, and state)
10. Usual Occupation CG Service
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name Mary ?
15. Birthplace ?

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 15-1945 (month) (day) (year)
(c) Cemetery or crematory Philadelphia Pa
Location Roff & B. M. Welte
18 (a) Funeral director Pratt Chesley Co
(b) Address

DEC 16 1945 (b) Registrar
(Date rec'd by registrar)

VS 190

MEDICAL CERTIFICATION A

20. DATE OF DEATH Dec. 14 1945, at 7:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 14 1945, to Dec. 14 1945, and that I last saw him alive on Dec. 14 1945.

Immediate cause of death	Duration
Coronary sclerosis with occlusion	?
Due to: Myocardial infarction acute	
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John L. Wilson, Sr. Surgeon M. D.
Address Clinical Director Date signed 12/15/45
US Marine Hospital, Balto, Md.

G35157 ✓ G35157

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3520 Hilton Rd.
(c) Hospital or institution: Ashburton Nursing Home. 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 70 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3520 Hilton Rd.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME NETTIE E. WEIL.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband ~~or wife~~ Henry Weil.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 17, 1869.

8. AGE: Years	Months	Days	If less than one day
76	1	28	hr. min.

9. Birthplace Cumberland, Md.
(Town, county, and state)
10. Usual Occupation None.
11. Industry or business

FATHER
12. Name ---------- Eichengreen,
13. Birthplace Germany.

MOTHER
14. Maiden Name Baweta Heisler,
15. Birthplace Germany.

16 (a) Informant Mr. Irving H. Weil,
(b) Address Frederick, Md.

17 (a) Burial (b) Date thereof 12.16.45.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Baltimore Hebrew
Location Balto. Md.

18 (a) Funeral Roberts Sons
(b) Address 1902 Eutaw Place.

19 (a) DEC 16 1945 (b) [illegible]
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 14th. 1945 at A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1942 to Dec. 14, 1945.
and that I last saw h. alive on Dec. 14, 1945.

Immediate cause of death: Myocardial Insufficiency — Duration: 1 Day
Due to: Arteriosclerosis
Due to: Hypertension
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Sister D. Levy
Address 2322 Eutaw Place Date signed M. 12 D. 15/45

G35158

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 939

G35158 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 703 Poplar-Grove St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ***
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 703 Poplar-Grove St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: John H. Wade

3 (b) If veteran, name war: ---

3 (c) Social Security Account No.: none

4. Sex: Male | 5. Color or race: Wht. | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Margaret E. Wade

6 (c) If alive, give age 78 years

7. Birth date of deceased (mo., day, yr.) Dec. 31, 1866

8. AGE: Years 78 | Months 11 | Days 14 | If less than one day ... hr. ... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Carpenter

FATHER
12. Name Thomas Wade
13. Birthplace Maryland

MOTHER
14. Maiden Name ? Ashpaugh
15. Birthplace Maryland

16 (a) Informant Mrs. Margaret E. Wade
(b) Address 703 Poplar-Grove St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 18, 1945 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location A.A.Co. Md.

18 (a) Funeral director Robert S. Little
(b) Address 2700 Edmondson Ave.

DEC 16 1945 (Date received by registrar) Clayton Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 14 1945, at P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-16-'39, to 12-14-'45, and that I last saw him alive on 12-13-'45

	Duration
Immediate cause of death: myocardial failure	2 days
Due to: arteriosclerotic heart disease	10 yrs.?
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature Harry L. Lundell
Address 2703 Edmondson Date signed 12-15-45

X

G35159 ✓ G35159

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 180

Registered No.

Please write the causes of death clearly and legibly. Correct age is especially important. Physicians: please write information should be carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1033 W. Lombard St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Louise Wagner

3 (b) If veteran, name war ---

3 (c) Social Security Account No. 212-12-4242

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 7, 1871

8. AGE: Years 74 | Months 2 | Days 7 | If less than one day ____ hr. ____ min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Seamstress

11. Industry or business

FATHER
12. Name Wm. H. Wagner
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Eckert
15. Birthplace Germany

16 (a) Informant Mrs. Catherine E. Smith
(b) Address 1033 W. Lombard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 17, 1945 (month) (day) (year)
(c) Cemetery or crematory Western
Location Balto. Md.

18 (a) Funeral director Robert S. Little
(b) Address 2700 Edmondson Ave.

19 (a) Dec 17 1945 (Date received by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-14 1945 at 6 15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-11 1945 to 12-14 1945, and that I last saw h[illegible] alive on 12-14 1945.

Immediate cause of death	Duration
Respiratory failure	
Due to Ist Degree burns face & both hands	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 0
Major findings of operation: 0
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: N/S
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 12-11-45 at M
(c) Where did injury occur? 1633 W. Lombard St (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Conflagration
23. Signature M. Dolores Clark
Address University Hospital Date signed 12-14-45 M.D.

VS 8 For S.P.J. Lubrano by Howard J. Mueller

G35160

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G35160 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City or Maryland
(b) Street address Fayette & Calhoun Sts
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3119 Belair Rd 2d (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Dougherty

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: David F.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6. 1865

8. AGE: Years 80 | Months 7 | Days 9 | If less than one day hr. min.

9. Birthplace Glascow Scotland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Andrew Toland

13. Birthplace Ireland

MOTHER 14. Maiden Name Sarah —

15. Birthplace —

16 (a) Informant Leo L. Dougherty

(b) Address 28-18th St S.E. Wash D.C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 18-1945 (month) (day) (year)

(c) Cemetery or crematory

Location Pittsburgh Penna

18 (a) Funeral director Pratt C. & B.M. Walter

(b) Address Pratt, Stricker Sts

19 (a) 6 1945 (Date rec'd by registrar) (b)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 15 1945 at 4 25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 30 1945 to Dec 15 1945 and that I last saw h. alive on Dec 15 1945

Immediate cause of death	Duration
Heart failure due to arterio sclerotic heart disease	?
Due to	
Due to	
Other Conditions Bronchopneumonia	7 days

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. B. Schreiber M. D.

Address 1 S. Fulton Ave Date signed 12-16-45

VS 150

G35161

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G35161
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1409 W. Lombard St.
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1409 W Lombard St.
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Wilmore Armstrong

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Marion K. (Armstrong)

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Aug 6 - 1865

8. AGE: Years 80 | Months 4 | Days 7 | If less than one day ... hr. ... min.

9. Birthplace Severn's Run, Md.
(Town, county, and state)

10. Usual Occupation Retired Farmer

11. Industry or business Farming

FATHER
12. Name George Armstrong
13. Birthplace Md

MOTHER
14. Maiden Name Sarah Gilbert
15. Birthplace Md

16 (a) Informant Mrs. Jesse A Dawson Jr
(b) Address 1409 W. Lombard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-17-45 (month) (day) (year)
(c) Cemetery or crematory Arlington
Location Arlington Md.

18 (a) Funeral director Geo. L. Berger Jr
(b) Address 1512 Hollins St.

19 (a) ... (b) ... (Signature of registrar)

6 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 13 1945, at 11:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1944 to Dec 12 1945 and that I last saw him alive on Dec 12 1945.

Immediate cause of death Arteriosclerotic Cardiovascular Disease — Duration ?

Due to ...

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at ... M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury —

23. Signature Carl A Rostering M. D.
Address 1326 W Lombard St Date signed 12/14/45

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35162

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G35162
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 920 Argonne Drive
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) 53 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 920 Argonne Drive
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Anna K. Thome

3 (b) If veteran, name war None

3 (c) Social Security Account No. None

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Michael Thome

6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) Sept. 10th 1871

8. AGE: Years 74 | Months 8 2 | Days 4 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Christian Heiman
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Ruggie
15. Birthplace Germany

16 (a) Informant Mrs. Elizabeth Lazar (Daughter)
(b) Address 920 Argonne Drive

17 (a) Burial (b) Date thereof 12/17/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) 12 16 1945 (b) [illegible] for William
(Date rec'd by registrar) Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 14 1945 at 1:00 A.M.

21. I certify that death occurred on the date above stated: that I attended deceased from Nov 15 1945 to Dec 4 1945 and that I last saw h[illegible] alive on Dec 3 1945

Immediate cause of death: Myocardial Insufficiency — Duration

Due to

Due to

Other Conditions Diabetes Mellitus Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John A. Schenuit M. D.
Address 1337 St. Charles St. Date signed 12/15/45

935

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35163

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

G35163 Registered No.

Type. Every item of information should be carefully supplied. Do not age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3508 Fait Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 76
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3508 Fait Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHRISTINE ZELLER

3 (b) If veteran, name war

3 (c) Social Security Account No. ------

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Widowed

6 (b) Name of husband or wife George Zeller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 14, 1859

8. AGE: Years	Months	Days	If less than one day
86	8	29	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business House-work.

FATHER
12. Name Sebastian Winterling
13. Birthplace Germany

MOTHER
14. Maiden Name Veronica Goldbach
15. Birthplace Germany

16 (a) Informant Matilda Zeller (Daughter)
(b) Address 3508 Fait Ave.

17 (a) Burial (b) Date thereof 12-17-45.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sacred Heart Cem.
Location German Hill Rd.

18 (a) Funeral director Charles S. Zeiler
(b) Address 3605 Fait Ave.

19 (a) DEC 16 1945 (b) Huntington Williams M.D.
(Date received by registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-13- 1945, at 7:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 8 1945 to Dec 13 1945 and that I last saw h[illegible] alive on Dec 13 1945.

Immediate cause of death	Duration
Cerebrovascular C.V. Disease	
Chronic Myocarditis	
Due to Congestive Failure	12-9-45
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ?
(b) Date of occurrence None at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature [illegible]
Address 842 S. Conkling Date signed 12-14-45 M. D.

X

G35164

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1122a

G35164 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 7-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 624 N. Decker Ct. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ludwig Geyer

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-05-5230

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Elizabeth Geyer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-23-73

8. AGE: Years	Months	Days	If less than one day
72	8	23	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Henry Geyer
13. Birthplace Germany.

MOTHER 14. Maiden Name Marie Rosch
15. Birthplace Germany.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 16 45 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel Cemetery
Location O'Donnell Street

18 (a) Funeral director Frederick D. Miller, Inc.
(b) Address 2017 E. Monument Street

DEC 16 1945 (c) Registrar Hennighausen

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-15 1945, at 8:36 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-27 1945 to 12-15 1945 and that I last saw him alive on 12-15 1945.

Immediate cause of death	Duration
Embolism ?	
Due to Post-operative phlebothrombosis	
Due to	
Other Conditions Anemia, Cystitis, pneumonia, s. to Salpingectomy	

(Include pregnancy within 3 months of death)

Date of operation 12-5-45

Major findings of operation: Large sessile fibroid tumor

of autopsy: not performed

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address Johns Hopkins Hosp. Date signed 12/16/45

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G35165 / 63B

Registered No. G35165

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address W. Fayette St
(c) Hospital or institution Bon Secure Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 W
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3407 Arunah Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Goldie Marks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1902

8. AGE: Years 43 | Months | Days | If less than one day hr. min.

9. Birthplace Balto, Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Max Mark
13. Birthplace Austria

MOTHER
14. Maiden Name Raph
15. Birthplace Russia

16 (a) Informant Mrs. Mary Mark
(b) Address 3407 Arunah Ave

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 12-17-45 (month) (day) (year)

(c) Cemetery or crematory Wiseman Circle
Location

18 (a) Funeral director Jos. H. Eura Inc
(b) Address 1435 E. Baltimore St Baltimore, Md

19 (a) 1945 (Registered by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 | 15 | 1945 at 3:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8 | 13 | 1945, to 12 | 15 | 1945, and that I last saw h[illegible] alive on 12 | 14 | 1945

Immediate cause of death: Congestive Heart Failure — Duration

Due to: Heart Arterio Sclerosis

Due to: Valvular Disease & Severe Aortic Insufficiency

Other Conditions: Hyperthyroidism
(Include pregnancy within 3 months of death)

Date of operation: None

Major findings of operation: None

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Thos Scott Jones, Jr. M. D.
Address 814 Sevens Bldg Date signed 12/17/45

VS 150

92a

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRESS WRITING FIRMLY, WITH UNFADING INK.

G35166

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G35166 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rutland & Ragnar
(c) Hospital or institution:
West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1949 W. North Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JENNIE Fannie Weiner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Israel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years 65 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation H. W.

11. Industry or business

FATHER
12. Name Israel
13. Birthplace Russia

MOTHER
14. Maiden Name Rachael —
15. Birthplace Russia

16 (a) Informant Mrs. HIGGER
(b) Address 1949 W. North Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-16-45 (month) (day) (year)
(c) Cemetery or crematory Mount Hebrew Cem.
Location

18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E. Balto. St.

12 16 1945 (Date received by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 14 1945, at 6:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-27 1945 to 12-14 1945 and that I last saw her alive on 12-14 1945

	Duration
Immediate cause of death Pulmonary edema	
Congestive Cardiac failure	
Due to Arteriosclerotic Cardiovascular disease	
Due to Cerebral Thrombosis and Cerebral Stenosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Med. Baltimore General Hosp. Date signed 12-14-45

VS 150

PRINT WITH PENCIL, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

635167 BALTIMORE CITY HEALTH DEPARTMENT 635167
CERTIFICATE OF DEATH 1937 Registered No.

Please write plainly, with unfading ink. Every item of information should be carefully supplied. Type correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution Sinai Hospt
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2113 Jefferson St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosenberg, Lena

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Joseph

(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years 68 | Months | Days | If less than one day hr. min.

9. Birthplace Russia. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Abraham

13. Birthplace Russia

MOTHER 14. Maiden Name Baula

15. Birthplace Russia.

16 (a) Informant Hosp Records

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-16-45 (month) (day) (year)

(c) Cemetery or crematory Workmens Circle

Location Mt Carmel

18 (a) Funeral director Jacob Lewis Inc

(b) Address 1439 E. Baltimore St

19 (a) 61945 (Date rec'd by registrar) (b) Huntington Wilson (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 15 1945, at 8:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 7 [illegible] to Dec. 15 1945, and that I last saw h.e.r. alive on Dec. 15 1945.

Immediate cause of death Pulmonary edema — Duration

Due to coronary failure

Due to Hypertension - arteriosclerotic heart disease

Other Conditions cerebral hemorrhage

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leonard Lebolin M. D.

Address Sinai Hospital Date signed Dec 15 1945

VS 150

X

G35168

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1/61

G35168 Registered No.

Please write plainly, with unfading ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai Hospt
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 32

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2817 Old Spring Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SARAH SINGER

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1902

8. AGE: Years	Months	Days	If less than one day
43			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Joseph Hordin
13. Birthplace Russia

MOTHER
14. Maiden Name Yetta
15. Birthplace Russia

16 (a) Informant Anna Singer
(b) Address 2817 Old Spring Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-16-45 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location

18 (a) Funeral director Jack Levine Inc
(b) Address 1439 E. Baltimore St

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 14 1945, at 1 00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 12 1945, to Dec 14 1945, and that I last saw her alive on Dec 14 1945.

Immediate cause of death pulmonary edema — Duration

Due to chronic heart failure

Due to Hypertensive heart disease

Other Conditions Diabetes mellitus
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Samuel Schulis M. D.
Address Sinai Hospital Date signed 12/19/45

VS 150

9513

G35169 — BALTIMORE CITY HEALTH DEPARTMENT — G35169

CERTIFICATE OF DEATH

136

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 930 W. Franklin St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 45yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 930 W. Franklin St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Washington Smallwood

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	C	Separated

6 (b) Name of husband or wife Florence
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 18, 1891

8. AGE: Years	Months	Days	If less than one day
54	0	24	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Porter
11. Industry or business

MOTHER / FATHER
12. Name Robert Washington
13. Birthplace South River, Md.
14. Maiden Name Jennie Boston
15. Birthplace South River, Md.

16 (a) Informant Nettie Ryan (Friend)
(b) Address 910 Pierce St (Friend)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/16/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 512 N. Carrollton Ave
19 (a) 6 1945 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 12th 1945; at 4:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 8 1945 to Dec 12 1945 and that I last saw h. alive on Dec 12 1945.

Immediate cause of death Pulmonary Tuberculosis — Duration 1 year
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John E. L. Compton M. D.
Address 630 N. Carey Date signed 12-19-45

VS 150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 94a S-35170

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Balto. City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 952 S. Bunny Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine G. Green

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~:
Female	White	Married

6 (b) Name of husband Frank T. Green
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 9th 1894

8. AGE: Years	Months	Days	If less than one day
51	11	5	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name Manuel Eaton
13. Birthplace Unknown

MOTHER
14. Maiden Name Ella Price
15. Birthplace Harford Co. Md.

16 (a) Informant William E. Bunner
(b) Address 920 S. Bunny St.

17 (a) Burial (b) Date thereof 12/19/45
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Mt Carmel
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) DEC 17 1945 Hunter Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-18- 1945, at 7:20 P.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to last death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mullen M.D.
Medical Examiner.
Date signed 12-19-45

write the causes of death clearly and legibly. Physicians: please write as legibly as possible. Type is especially important.

35 [illegible] (G35[illegible])

✓ S-35[illegible]

(G35[illegible])

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2710 Twenty One Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2710 Twenty One Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John C Grant

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife Anna O.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 22 1862

8. AGE: Years	Months	Days	If less than one day
83	2	22	hr. min.

9. Birthplace Fort Defiance Md
(Town, county, and state)
10. Usual Occupation Iron Moulder Retired
11. Industry or business

FATHER
12. Name George V Grant
13. Birthplace Md

MOTHER
14. Maiden Name Mary E Watkinson
15. Birthplace Md

16 (a) Informant Anna M Gilbert
(b) Address 2710 Twenty One Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/17/45 (month) (day) (year)
(c) Cemetery or crematory Woodland Park
Location Baltimore Md

18 (a) Funeral director Tillman & Son
(b) Address 1217 E. Fayette St

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. (Registrar)

DEC 17 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 14 1945, at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1943 to Dec 14 1945 and that I last saw h[illegible] alive on Dec 13 1945

Immediate cause of death

	Duration
Bronchopneumonia	5 days
Due to Arteriosclerosis	10 yrs
Due to Brights Disease	10 yrs
Other Conditions Old man	—

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward C Grimm M. D.
Address 9858 Dayton Ave Date signed 12-18-45

VS 150

X

35172 S-35172

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107 Registered No.

The entry of information should be carefully supplied. Every item of information should be carefully supplied. Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2211 Rogers Ave
(c) Hospital or institution: Aged Home of M.E. Church
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2y
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2211 Rogers Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maria Price

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 6, 1862

8. AGE: Years	Months	Days	If less than one day
83	8	9	hr. min.

9. Birthplace Anne Arundel Co Md
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name John Price
13. Birthplace Montgomery Co Md

MOTHER
14. Maiden Name Rachel Anderson
15. Birthplace Anne Arundel Co Md

16 (a) Informant Mrs A O Savage
(b) Address 2211 Rogers Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/19/45 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore Md

18 (a) Funeral director Wilson Colston
(b) Address 217 N Fremont St

19 (a) DEC 17 1945 (Date rec'd by registrar) (b) Interim for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 19 1945, at 12 05 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 10 1945 to Dec 14 1945 and that I last saw h[illegible] alive on Dec 14 1945

Immediate cause of death	Duration
Bronchial Pneumonia	3 days
Due to Arteriosclerosis	10 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Arthur J Davies M. D.
Address 800 N 33rd Date signed 12-16-45

VS 150

G35173

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 43a

G35173 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1900 Dixon Road
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town 1900 Dixon Road
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Caspar Sourr

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-05-9237

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of ~~husband or~~ wife Bertha E. Sourr
6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) Oct 16 - 1880

8. AGE: Years	Months	Days	If less than one day
65	1	28	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Street Name Dealer
11. Industry or business Retired

FATHER
12. Name Wm. Philip Sourr
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Mary Burgert
15. Birthplace Baltimore Md

16 (a) Informant Bertha E. Sourr
(b) Address 1900 Dixon Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-17-45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director William Cook Inc.,
(b) Address 1217 St Paul St

(a) DEC 17 1945 Huntington Williams M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 14 1945, at 8:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 5 1945 to Dec 13 1945, and that I last saw h~~im~~er alive on Dec 12 1945.

Immediate cause of death: Cerebral hemorrhage
Arterio Sclerosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Benjamin Kadan M. D.
Address 2306 Eutaw Pl Date signed 12-15-45

VS 180

G35174 ✓ G35174

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 322 East 27th St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 322 East 27th St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANK W. WOLF

3 (b) If veteran, name war None
3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Caroline E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APRIL 14, 1876

8. AGE: Years 69 | Months 8 | Days 0 | If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business Makes Wines & Liquors

FATHER 12. Name (Unknown) Wolf

13. Birthplace "

MOTHER 14. Maiden Name "

15. Birthplace "

16 (a) Informant Mrs Caroline E. Wolf
(b) Address 322 E. 27th st.

17 (a) Entombment (Burial, cremation, or removal) (b) Date thereof 12/18/45 (month) (day) (year)

(c) Cemetery or crematory Woodlawn Mausoleum
Location Md

18 (a) Funeral director Williams Carter Sons
(b) Address 1217 St. Paul St.

19 (a) 12 17 1945 (Date rec'd by registrar) (b) Certificate for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-14 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 14 1945 to Dec 14 1945, and that I last saw h alive on Dec 14 1945.

Immediate cause of death Coronary Thrombosis — Duration 4 hr

Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ✓
(b) Date of occurrence ✓ at M
(c) Where did injury occur? ✓ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edgar Talbot M.D.
Address 2723 St Paul St Date signed 12/17/1945

X

VS 150

G35175

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48B

Registered No. G35175

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Street City
(c) Hospital or institution:
Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day 9 mos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louise Owens né - Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	married

6 (b) Name of husband or wife Lawrence Owens
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) May. 8, 1868

8. AGE: Years	Months	Days	If less than one day
77	7	6	hr. min.

9. Birthplace South Carolina
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Henry Jones
13. Birthplace South Carolina

MOTHER
14. Maiden Name Henrietta Alston
15. Birthplace South Carolina

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley Street City

17 (a) Burial (b) Date thereof Dec 17 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 914 Fremont Ave

(a) DEC 7 1945 Registrar
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec - 14 - 1945 at 5-45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 10 1945 to Dec 14 1945 and that I last saw her alive on Dec 14 - 1945

Immediate cause of death	Duration
Edema Lungs	1 day
Due to Carcinoma of Uterus	2 yrs
Due to	
Other Conditions Metastasis in Lungs	2 months

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E Gill Hall M. D.
Address 16 318 North Ave Date signed Dec 16-45

VS 150

635176

BALTIMORE CITY HEALTH DEPARTMENT

DEC 17 1945

CERTIFICATE OF DEATH 937

Registered No. 635176

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eaton & Welkens Ave
(c) Hospital or institution:
St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4301 Roland Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Boylan

3 (b) If veteran, name war: W

3 (c) Social Security Account No. one

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 2nd 1945

8. AGE: Years 74 | Months 5 | Days 9 | If less than one day: hr. min. 11

9. Birthplace Iowa
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business Home for Aged

FATHER
12. Name Daniel Sullivan
13. Birthplace Ireland

MOTHER
14. Maiden Name Julia Mahoney
15. Birthplace Ireland

16 (a) Informant Mrs Catherine Trenkart
(b) Address San Diego Calif

17 (a) Removal (b) Date thereof 12/16/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Eden Valley
Location Minnesota

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

DEC 17 1945 (Date rec'd by Registrar) Permit for Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/11 19 45 at 5:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/26 19 45 to 12/11 19 45 and that I last saw h. alive on 12/11 19 45

Immediate cause of death: Cardiac - Resp. failure — Duration

Due to Cardiac failure & Pulmonary Edema — Duration

Due to Arteriosclerotic C-V Disease. — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thos. E. Carr M.D.
Address 1 Olympic Bldg Date signed 12/11/45

Carr — X

G351717

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G351717

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland U.S. Marine Hospital Baltimore 11 MD.

(b) Street address

(c) Hospital or institution: Hospital.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-25-45 until death

(e) Length of stay in Baltimore (yrs., mos., or days) 12-14-45

2. USUAL RESIDENCE OF DECEASED:

(a) State Pa. (b) County Phila.

(c) City or town Phila. Pa.
(If outside city or town limits, write RURAL and give town)

(d) Street No. 529 N. 20th St Phila, Pa
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** John Joseph Furey.

3 (b) If veteran, name war

3 (c) Social Security Account No. ?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Widower.

6 (b) Name of husband or wife deceased (wife)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 12, 1889.

8. AGE: Years	Months	Days	If less than one day
56	2	32	hr. min.

9. Birthplace Boston, Mass.
(Town, county, and state)

10. Usual Occupation Merchant Seaman

11. Industry or business M.S.

FATHER 12. Name Catherine Hickey Furey.

13. Birthplace Boston Mass.

MOTHER 14. Maiden Name Thomas J. Furey.

15. Birthplace Boston Mass.

16 (a) Informant Next of Kin

(b) Address

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 12-16-45 (month) (day) (year)

(c) Cemetery or crematory MAUCH CHUNK, PA

Location MAUCH CHUNK, PA

18 (a) Funeral director WILLIAM COAK, INC.

(b) Address 1217 ST. PAUL ST.

DEC (a) 17 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-14 1945, at 5:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-25 1945 to 12-14- 1945, and that I last saw him alive on 12-14-45 19

Immediate cause of death Arteriosclerotic Heart Disease

Duration Lifetime

Due to Arteriosclerosis generalized

Due to Cardiac Failure due to above

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None.

Major findings of operation: none.

of autopsy: Confirmed above diagnosis

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature W.S. Hooper (C.D.) M. D.

Address U.S. Marine Hospital Baltimore Md Date signed 12-16-45

Cover

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G35178

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G35178 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 106 W North Ave
(c) Hospital or institution: at Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0 17
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 106 W North Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Bessie Burns Bennett

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: Single.
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept-16-1876

8. AGE: Years 69 | Months 2 | Days 29 | If less than one day: ___ hr. ___ min.

9. Birthplace Baltimore (Town, county and state)

10. Usual Occupation Teacher

11. Industry or business Girls Latin School

FATHER
12. Name Gofaith R. Bennett
13. Birthplace Virginia

MOTHER
14. Maiden Name Lillie Carter
15. Birthplace Alabama

16 (a) Informant Miss Lilly B. Bennett
(b) Address 106 W North Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-17-45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Sherwood Memorials
(b) Address 108 W North Ave.

19 (a) ___ (Date received by registrar) (b) ___ Registrar

DEC 17 1945

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 15, 1945, at 9 30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-9-1945, to 12-15-1945, and that I last saw h[illegible] alive on 12-14-1945.

Immediate cause of death Chronic Nephritis with Anasarca — Duration 6 mo.

Due to ___

Due to ___

Other Conditions Hypertension — 7

(Include pregnancy within 3 months of death)

Date of operation ___

Major findings of operation: ___

of autopsy: ___

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ___
(b) Date of occurrence ___ at ___ M
(c) Where did injury occur? ___ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ___ (Specify type of place) While at work? ___
(e) Means of injury ___

23. Signature Maurice E. Shannon M. D.
Address 3300 W. North Ave Date signed 12/16/45

X

G35179

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

52a

Registered No. G35179

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2422 Md Ave

(c) Hospital or institution: athome

(d) Length of stay in hospital or inst. (yrs., mos., or days) 0

(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Baltimore

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2422 Md Ave (If rural, give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Sarah Elizabeth Hasson

3 (b) If veteran, name war: no

3 (c) Social Security Account No. no

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Frank Wilson Hasson

6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) Nov 6 1880

8. AGE: Years 65 | Months 1 | Days 9 | If less than one day: hr. min.

9. Birthplace Carroll Co. Md (Town, county, and state)

10. Usual Occupation none

11. Industry or business none

FATHER

12. Name Geo. F. Gorsuch

13. Birthplace Carroll Co.

MOTHER

14. Maiden Name Anna S. Kellar

15. Birthplace Carroll Co.

16 (a) Informant Mrs. O. Hasson (husband)

(b) Address 2422 Md Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 18-45 (month) (day) (year)

(c) Cemetery or crematory Baltimore

Location Baltimore

18 (a) Funeral director Sturdivant Mayne Co.

(b) Address 1084 Main Ave Wilmington Delaware

19 (a) DEC 17 1945 (Date received by Registrar) (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/15/45 1945, at 7 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1943 to Dec 14 1945; that I last saw her alive on Dec 13 1945

Immediate cause of death: Carcinoma

Due to: Primary of Kidney

	Duration
	2 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 1944

Major findings of operation: Carcinoma of Kidney (removed)

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature W F Heady M. D.

Address 1402 Park Ave Date signed 12/16/45

(over)

635180

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

635180 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 917 N Vincent St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give county)
(d) Street No. 917 Vincent St (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Calvin Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 17 1945

8. AGE: Years | Months: 5 | Days: 29 | If less than one day: hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Calvin Countess
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Sherley Smith
15. Birthplace Maryland

16 (a) Informant Sherley Smith
(b) Address 917-N. Vincent st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/17/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location H. A. Co. Md.

18 (a) Funeral director Chas. H. Alexander
(b) Address 927 N. Monroe St

19 (a) DEC 17 1945 (Date rec'd by registrar) Huntington Williams Registrar

VS 6

MEDICAL CERTIFICATION

20. DATE OF DEATH 15 Dec 1945, at 12:30 P.M.

21. I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry thereon (Autopsy or Inquiry) and from the evidence obtained by said Inquiry (Autopsy or Inquiry) find that said deceased came to His death on the day stated above.

Immediate cause of death: Pneumonia, lobar — Duration —
Due to
Due to
Other Conditions: Non —
(Include pregnancy within 3 months of death)
Major findings:
Of operations —
Of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William G Hofheimer M.D.
Medical Examiner
Date signed 15 Dec 45 Investigator

G35181

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G35181

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Parkland & Rayner
(c) Hospital or institution M.B.G.H.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 35

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2810 Waldorf Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Abraham Feldman

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Tillie
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) — — 1875

8. AGE: Years	Months	Days	If less than one day
70			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business

FATHER
12. Name ? Unkown
13. Birthplace Russia

MOTHER
14. Maiden Name ?
15. Birthplace Russia

16 (a) Informant Harry Feldman
(b) Address 2810 Waldorf Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof December 18, (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cem
Location Hamilton Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) (Date rec'd by registrar) (b) Huntington-Williams, inc Registrar

DEC 17 1945

vs 190

MEDICAL CERTIFICATION

20. DATE OF DEATH 16 Dec 19 45 at 1:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-15-45 to 12-16-45 19 45, and that I last saw h[illegible] alive on 16 Dec 19 45

Immediate cause of death Respiratory Failure — Duration
Due to Cerebral Embolism
Due to Auricular Fibrillation
Due to Mural Thrombus
Other Conditions Myocardial Infarction

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lester C Steel Jr. M. D.
Address U.B. General Hosp Date signed

Signature of Registrar Howard J. Mueller, M.D. X

PRESS WRITE FIRMLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35182

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 134a

Registered No. G35182

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai Hospt
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3900 Fairfax Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frieda Brenner

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married.

6 (b) Name of husband or wife Isaac

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years 68 | Months | Days | If less than one day ...hr. ...min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Morton
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Hosp Records
(b) Address

17 (a) Burial (b) Date thereof 12-17-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Walkemyer Cmtl
Location Mt. Carmel.

18 (a) Funeral director Jos. Levi Son
(b) Address 1439 E. Balto St

19 (a) DEC 17 1945 (b)
(Date received by Registrar) Registrar

Huntington Hillcrest, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 16 1945 at 7 25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 25 1945 to Dec 16 1945 and that I last saw h[er] alive on 12- 1945

Immediate cause of death Uremia, pneumonia pyelonephritis

Due to Staghorn calculus + Kinking of right ureter

Due to

Other Conditions Hypert. arteriosclerotic heart disease
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Daniel Hamburger M. D.

Address Sinai Hosp Date signed 12-16-45

635183

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

Registered No. 635183

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4618 Belair Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4618 Belair Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME THOMAS G. DORSEY

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Alverta Dorsey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1, 1863

8. AGE: Years	Months	Days	If less than one day
82	6	14	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Printer
11. Industry or business Sunpapers

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs. T. G. Dorsey
(b) Address 4618 Belair Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 18, 1945 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Balto., Md.

18 (a) Funeral director Loudon Funeral Home
(b) Address 7401 Belair Road

DEC 17 1945 (Date rec'd by Local Registrar) Municipal for Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH December 15, 1945, at 12:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1945, to Dec 15 1945.
and that I last saw him alive on Dec 14 1945.

Immediate cause of death	Duration
Chronic Myocarditis	
Due to Arteriosclerosis	
Due to Hypertension	
Other Conditions Gastric Carcinomas	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Walter A Anderson M. D.
Address 300 Shannon Drive Date signed

93 Dec 17-45

VS 189

DEATHS WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

635184

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

✓ 635184 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 940 S. Sharp St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 940 S. Sharp St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maggie Adams
3 (b) If veteran, name war — (c) Social Security Account No.

4. Sex: female | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1878
8. AGE: Years 67 | Months | Days | If less than one day hr. min.
9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business unemployed

FATHER
12. Name Isaiah Rose
13. Birthplace Md.

MOTHER
14. Maiden Name Louise Rose
15. Birthplace Md.

16 (a) Informant Carry Sheridan
(b) Address 1005 Penna. Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/17/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location
18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Blankley Ave
(c) Date rec'd by registrar DEC 17 1945 Registrar Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 13 1945 at 6:45 A M
21. I certify that death occurred on the date above stated; that I attended deceased from Dec 7 1945 to Dec 13 1945 and that I last saw h-er alive on Dec 12 1945

Immediate cause of death	Duration
Acute Intestinal obstruction	7 days
Due to Chr. Int. Obstruction	uncertain
Due to Carcinoma of Intestines	uncertain
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature John W. Gaines M.D.
Address 607 W. Hamburg St Signed 12/15/45

VS 150

G35185

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 82a

G35185 Registered No.

write the causes of death clearly and legibly. Physicians: please write correct age as especially important. Use typewriter supplies. Use

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 44 W. West St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Williams

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col.	M

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) [illegible]

8. AGE: Years	Months	Days	If less than one day
57			hr. min.

9. Birthplace A.A Co., Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Alatha Williams
(b) Address 500 Asquith St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-19-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery
Location

18 (a) Funeral director Elroy D. Wilson
(b) Address 1000 Brent Lane

DEC 17 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 13 1945 at 5:10 a.m.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Intra-cerebral Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☑ cause of death, fill in the following:
(a) Date of injury December 9 1945 M.
(b) Where did injury occur Charles & Wheeling Sts
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Fall on street

23. Signature Benedict Steracile M.D. Medical Examiner.
Date signed 12-13-45

VS 151

G35186

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G35186
Registered No.

TN. 97648

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals 22
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 850 S. Eutaw St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Janie Hines

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1st 1884

8. AGE: Years 61 | Months 7 | Days 13 | If less than one day ... hr. ... min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Ethan Kennary
13. Birthplace Va.

MOTHER
14. Maiden Name Lucy Powell
15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-18-45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy O Wilson
(b) Address 1000 Brantley ave
(c) Huntington Williams Md

DEC 17 1945
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-14-45 19 , at 2.30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-3-45 19 , to 12-14- 1945 , and that I last saw her alive on 12-14-45 19

Immediate cause of death: Pulmonary Tuberculosis — Duration: 2

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert B. Copeland Jr.

Address Balt. City Hosp. Date signed 12/16/45 M. D.

VS 150

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35187

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

104

Registered No. G35187

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dukeland & Rayner
(c) Hospital or institution: West Balto Gen Hosp. 13-b
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 1 month

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town 357 Baltimore - 11
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3514 Elmo Ave
(Street and house location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Larry Eugene Crawford

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8 Nov. '45

8. AGE: Years	Months	Days	If less than one day
	1	7	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Baby
11. Industry or business —

FATHER
12. Name Ernest Crawford
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Ada King
15. Birthplace Baltimore

16 (a) Informant Ada Crawford (mother)
(b) Address 3514 Elmo Ave

17 (a) Removal-Family (b) Date thereof Dec. 17 '45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Mary's
Location Hampden.
18 (a) Funeral director L. Hemmerich & Son
(b) Address 2405-17 Eastern Ave.
19 (a) DEC 17 1945 (b) Inspector Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 15 Dec. 1945, at 6.35 M
21. I certify that death occurred on the date above stated; that I attended deceased from 15 Dec 1945 to 15 Dec 1945 and that I last saw him alive on 15 Dec 1945

Immediate cause of death	Duration
Respiratory Obstruction	
Atelectasis	
Due to Pneumonia, bilateral	
Due to Neonatorum (5 weeks)	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work
(Specify type of place)
(e) Means of injury
23. Signature Lester Williams M.D.
Address West Balt. Gen Hosp. Date signed 12/16/45

VS 150

635188

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 635188

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 612 W. Fairmount Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Susan Alton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife John Alton

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 20. 1879

8. AGE: Years 66 | Months 0 | Days 24 | If less than one day hr. min.

9. Birthplace Anne Arundel County Md
(Town, county, and state)

10. Usual Occupation Home wife

11. Industry or business

FATHER 12. Name Samuel Power

FATHER 13. Birthplace Anne Arundel County Md

MOTHER 14. Maiden Name Mary

MOTHER 15. Birthplace Anne Arundel County Md

16 (a) Informant Lena Purnell Daughter

(b) Address 612 W. Fairmount ave

17 (a) Burial (b) Date thereof Dec 19. 1945
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mount Auburn Cemetery

Location Baltimore City

18 (a) Funeral director Joseph A. Lively

(b) Address 409 N. Mount Street

19 DEC 17 1945 (b)
(Date received by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 14 1945, at 8 15 M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebro vascular
cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.

Date signed Dec. 15 1945

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

635189

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

635189 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N CAROLINE ST
(c) Hospital or institution: ST JOSEPH'S HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 16 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County BALTO
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 618 COKESBURY AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME PAUL J. FERNANDEZ

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-20-0478

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DECEMBER 3 1928

8. AGE: Years	Months	Days	If less than one day
17	10	12	hr. min.

9. Birthplace BALTIMORE Md.
(Town, county, and state)
10. Usual Occupation DEFENSE WORK
11. Industry or business Telephone Co

FATHER
12. Name John Fernandez
13. Birthplace Spain

MOTHER
14. Maiden Name Louise Delgano
15. Birthplace England

16 (a) Informant St Joseph Hospital
(b) Address 1400 N. Caroline St.

17 (a) Burial (b) Date thereof 12/18/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mount Holy Redeemer
Location Belair Road

18. (a) Funeral director Joseph Fanaco Inc.
(b) Address 2013 Fleetmount Ave

19 (a) (b)
(Date received by registrar) Registrar

DEC 17 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 15 DEC. 1945 at 1:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 14 Dec 1945 to 15 Dec 1945; and that I last saw h.e.r alive on 14 Dec 1945.

Immediate cause of death	Duration
Cardio-Respiratory Failure	
Due to METASTATIC SARCOMA TO LUNGS.	
Due to SYNOVIAL SARCOMA Right THIGH	
Other Conditions C.O.R. PULMONALE	

(Include pregnancy within 3 months of death)
Date of operation 6/9/45
Major findings of operation: SYNOVIAL SARCOMA RIGHT THIGH
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature Clarence W Martin M. D.
Address St Joseph Hospital Date signed 18 Dec 45

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G35190 48a G35190

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Laynor & Fayette Sts.
(c) Hospital or institution: Bon Secours Hospt
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Howard
(c) City or town Elkridge.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1951 Frankel Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julia Skrivanek

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow.

6 (b) Name of husband or wife Late Anton

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 4 1867

8. AGE: Years 78 | Months 0 | Days 1 | If less than one day hr. min.

9. Birthplace Czechoslovakia (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business at home

FATHER
12. Name John Tyora
13. Birthplace Czechoslovakia

MOTHER
14. Maiden Name Urbanek
15. Birthplace Czechoslovakia

16 (a) Informant Mrs. Charles Roddick
(b) Address 2066 Sunset Ave, Elkridge

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/18/45 (month) (day) (year)
(c) Cemetery or crematory St Augustine Cem
Location Elkridge, Md

18 (a) Funeral director John C. Conway & Son
(b) Address 901-07 Hollins Street

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-15 1945, at 7 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-7 1945 to 12-15 1945, and that I last saw h[illegible] alive on 12-15 1945

Immediate cause of death	Duration
Carcinoma of Cervix	2 yrs?
Due to Precidentia of Uterus	15 Yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Richard C. Hayden M. D.
Address Bon Secours. Date signed 12-16-45

VS 150 DEC 17 1945

PRINT WITH PENCIL, WRITE UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35191 G

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G35191 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens + Catonsville
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Howard
(c) City or town Ellicott City
(If outside city or town limits, write RURAL and give town)
(d) Street No. Patapsco Heights
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Michael Sullivan
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Rose M
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept 27 - 1874
8. AGE: Years 70 | Months 2 | Days 18 | If less than one day — hr. min.
9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Post Master
11. Industry or business Ellicott City, Md.

FATHER
12. Name Barney Sullivan
13. Birthplace Ireland

MOTHER
14. Maiden Name Annie Flynn
15. Birthplace Ireland

16 (a) Informant Mrs. William J. Malone
(b) Address 4500 Ridgewood Ave, Baltimore
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/19/45 (month) (day) (year)
(c) Cemetery or crematory St Augustines Cem
Location Oakridge, Md.
18 (a) Funeral director John F. Corcoran & Son
(b) Address 901-03 N. Eden St
19 (a) (Date rec'd by registrar) (b) Registrar

DEC 17 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-15-1945 at 10:45 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 12-12-1945 to 12-15-1945 and that I last saw him alive on 12-13-1945

	Duration
Immediate cause of death: Cardiac Resp. Failure	
Due to: Pulmonary Edema (acute)	
Due to: Chronic Myocardial Degeneration + Cardiac Failure	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas E Carroll M.D.
Address St Agnes Hosp Date signed 12/15/45

G35192

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G35192 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 521 W. Barre St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 521 W. Barre St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martha ann Taylor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F.

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 10, 1945

8. AGE: Years — Months — Days 4 If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Wm Willie Taylor
13. Birthplace Littletown N.C.

MOTHER
14. Maiden Name Emma Alston
15. Birthplace Littletown N.C.

16 (a) Informant Univ. Hosp Records
(b) Address C. L. Jacobson M.D.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location University Medical School NOV 20 1945
(Commissioner of Health)

18 (a) Funeral director
(b) Address

19 DEC 17 1945 (b) Registrar
(Date rec'd by registrar)

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 13 14 1945, at M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Prematurity
Dehydration
Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skotaelis M.D.
Medical Examiner.
Date signed 11-15-45

309 1/2 OUEN X

Please write the causes of death clearly and legibly. Physicians: please write in every applicable item.

G35193

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G35193
Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4013 Liberty Heights Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Rockdale
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3602 Kenmar Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Sarah Elizabeth Rush

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Campion Rush

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9 22 1853

8. AGE: Years: 92 | Months: 4 | Days: 22 | If less than one day: hr. min.

9. Birthplace Balto Co Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business at home.

FATHER
12. Name Solomon Welch
13. Birthplace N.J.

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Campion W. Rush Sr.
(b) Address 3602 Kenmar Road Rockdale Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 17/1945 (month) (day) (year)
(c) Cemetery or crematory London Park.
Location Baltimore Md.

18 (a) Funeral director Harry A Dunnock
(b) Address 4202 Ridgewood Ave

19 (a) DEC 15 1945 (Date rec'd by local Registrar) (b) Cunningham Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 14 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1945 to 1945, and that I last saw h alive on 12-14 1945.

	Duration
Immediate cause of death: Cerebral Vase accident	2 days
Due to: Generalized Arteriosclerosis	35 yrs.
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thos E Offutt M. D.
Address 430 Edgevale Rd Date signed 12-15-45

VS 186

G35194 G35194

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

D. 96959

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-15 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1513 E. Lombard St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Morris Bailey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 12th 1874

8. AGE: Years	Months	Days	If less than one day
70	3	2	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Norman Bailey
13. Birthplace Va.

MOTHER
14. Maiden Name Emma Solley
15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 17/45 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary Cem.
Location A. A. County Md.

18 (a) Funeral director Mrs. Robert A. Ellis & Dgt
(b) Address 1129 N. Caroline St.

19 (a) DEC 17 1945 (b)
Filed by Registrar
Huntington Williams, MD Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-14-45 19 , at 9.45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-29-45 19 , to 12-14- 1945, and that I last saw h im alive on Dec. 14 19 45

Immediate cause of death	Duration
Cerebral Thrombosis	?
Due to Hypertension	
Arteriosclerosis	
Due to	
Other Conditions	
(Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy: HCVD fatty liver. Arteriosclerosis	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Marguerite Bonn M. D.
Address 4940 Eastern Ave. Date signed 12-15-45

83B

G35195

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

✓ G35195 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dukeland & Laynes Ave
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2700 Roslyn Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Floyd L Cronhardt

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 212-01-6554

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Luella Mae
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 31, 1875

8. AGE: Years	Months	Days	If less than one day
70	1	13 14	hr. min.

9. Birthplace Cronhardt, Md.
(Town, county, and state)
10. Usual Occupation Sales Representive
11. Industry or business Standard Register Co.

MOTHER / FATHER
12. Name John Cronhardt
13. Birthplace Cronhardt, Md.
14. Maiden Name Emma Jessup
15. Birthplace Md.

16 (a) Informant Mrs. Luella Mae Cronhardt
(b) Address 2700 Roslyn Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/18/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Rd.

18 (a) Funeral director William J. Tickner & Sons
(b) Address North & Pa. Aves.

19 (d) DEC 17 1945 (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION 36

20. DATE OF DEATH Dec 14 1945, at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 14 1945, to Dec 14 1945, and that I last saw h[illegible] alive on Dec 14 19 45.

Immediate cause of death	Duration
Gangrene, Diabetes	
Due to Pulmonary edema	
Due to Diabetes Mellitus	
Due to Arteriosclerotic Cardiac	
Other Conditions Lymphatic Leukemia	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Floyd L Baldwin M. D.
Address West Baltimore General Hosp. Date signed 12-14-45

VS 150

G35196 G35196

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5506 South Bend Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 60yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5506 South Bend Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas H. Ruddock

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Hanna R.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 7, 1863

8. AGE: Years	Months	Days	If less than one day
82	8	7	hr. min.

9. Birthplace Birmingham, England (Town, county, and state)
10. Usual Occupation Elevator Construction
11. Industry or business

FATHER
12. Name Thomas W. Ruddock
13. Birthplace England

MOTHER
14. Maiden Name Isabelle V. Potter
15. Birthplace England

16 (a) Informant Mrs. William W. Werking
(b) Address 5506 South Bend Rd.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 12/17/45 (month) (day) (year)
(c) Cemetery or crematory Washington D.C.
Location

18 (a) Funeral director William J. Tickner & Sons
(b) Address North & PA. Aves.

DEC 17 1945 (Date rec'd by registrar) (b) Huntington Williams III Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 14 1945 at 11.00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/13 1945 to 12/14 1945 and that I last saw him alive on 12/14 1945

Immediate cause of death	Duration
a. Cerebral Embolism	1 hr.
Due to Arterio-sclerosis	Several yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Hugh Greenall M.D.
Address 3902 Keswick Rd Date signed 12/13/45

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35197

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

47c

G35197
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dukeland & Raysor
(c) Hospital or institution: Fort Bard Gen Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 44
(e) Length of stay in Baltimore (yrs., mos., or days) 66

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city limits, write RURAL and give town)
(d) Street No. 5406 Park Heights Ave
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Ruark

3 (b) If veteran, name war: None —

3 (c) Social Security Account No.: None

4. Sex: F

5. Color or race: W.

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Milton J. Ruark

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 14 June 1879

8. AGE: Years 66 | Months 6 | Days 2 | If less than one day hr. min.

9. Birthplace Germany Baltimore. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Herman Betz
13. Birthplace Hamburg Germany

MOTHER
14. Maiden Name Sophie Betz
15. Birthplace Hamburg, Germany

16 (a) Informant Mr. Milton H. Ruark.
(b) Address 4319 Mabelhall Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/19/45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn, Balto. Co. Md.

18 (a) Funeral director Wm. J. Tickner & Sons, Inc.
(b) Address North & Pa. Aves., Balto. Md.

19 (a) DEC 17 1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 16 1945 at 7:27 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19..., to 19..., and that I last saw h... alive on 19...

Immediate cause of death: Resp. Failure — Duration:
Due to: Carcinomatosis, Ovaries
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?: (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?: While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: Louis G. Hasel M. D.
Address Wash. Blvd. & Lem. Ave. Date signed 12/19/45

VS 150

G35198

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46D

G35198 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 729 S. Potomac St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 76 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 729 S. Potomac St
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Emma V. Diggs

3 (b) If veteran, name war none
3 (c) Social Security Account No. none

4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced. Widowed
6 (b) Name of husband or wife Joseph M. Diggs
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) 30 Jan. 1869

8. AGE: Years 76 | Months 10 | Days 15 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Hartley
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Seward
15. Birthplace Baltimore, Md

16 (a) Informant Mrs. Lillian Toon
(b) Address 729 S. Potomac St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/19/45 (month) (day) (year)
(c) Cemetery Oak Lawn Cem.
Location 7225 Eastern Ave.

18 (a) Funeral director Stephen J. Fialkowski Inc.
(b) Address 1000 E. Lenwood ave

19 (a) ____ (b) ____ (Date rec'd by registrar) Registrar

DEC 17 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 15 1945 at 11:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 3 1945 to Dec 15 1945
and that I last saw her alive on Dec 15 1945

Immediate cause of death: Hypostatic Pneumonia — Duration 12/11/45
Due to: ____
Due to Anemia of Chronic — 11/3/45
Other Conditions: ____
(Include pregnancy within 3 months of death)
Date of operation: ____
Major findings of operation: ____
of autopsy: ____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ____
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? ____
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ____ While at work? ____
(Specify type of place)
(e) Means of injury ____

23. Signature William J. Roarer M.D.
Address 801 N Kenwood Ave Date signed 12/18/45

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRINT WITH UNFADING INK.

G35199

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183a

G35199 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1919 Annunah Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) [illegible]
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1919 Annunah Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William McLean Foster

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-12-2180

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Mary L Foster (husband)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 15 1881

8. AGE: Years	Months	Days	If less than one day
64	10	28	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Painter
11. Industry or business

FATHER
12. Name Thomas E Foster
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Jane McLean
15. Birthplace Baltimore

16 (a) Informant Mrs Foster Son
(b) Address 1919 Annunah

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 18 1945 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location

18 (a) Funeral director Chas P Powell
(b) Address 2427 Edmondson Ave

19 (a) (Date received by local registrar) (b) Registrar

DEC 17 1945 Hunting for Hillcrest, Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 16 1945, at 7:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from JAN 1945 to DEC 16 1945 and that I last saw h[illegible] alive on Dec 15 1945

Immediate cause of death Respiratory failure

Due to Subpericardial tumor bigeminy

Due to Generalized arteriosclerosis and Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. Shoofstall MD

Address 601 N. Monroe St Date signed 12/17/45

X

635200

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157 E

Registered No. 635200

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Catonsville Aves.
(c) Hospital or institution: St. Agnes Hospital 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5 S. Rosedale St. - 29
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Andrews

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-10-45

8. AGE: Years	Months	Days	If less than one day
		5	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name William
13. Birthplace Greece

MOTHER
14. Maiden Name Bessie Dimoglou
15. Birthplace Greece

16 (a) Informant William Andrews
(b) Address 5 S. Rosedale St.

17 (a) Burial (b) Date thereof 12/17/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Catholic
Location Baltimore

18 (a) Funeral director Martin Fahey & Sons
(b) Address 1827 W. North Ave.

19 (a) DEC 17 1945 (b) Date rec'd (Registrar) Printing for Williamsett

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 15 1945 6:34 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-10 45 to 12-15 1945, and that I last saw [illegible] alive on 12-15 1945

Immediate cause of death Cardiac Failure — Duration

Due to Congenital Heart Disease

Due to (one chambered Ventricle & transposed great vessels)

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo. N. D'Elia Jr.

Address St. Agnes Hosp. Date signed 12/16/45 M. D.

G35201

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G35201 Registered No.

Please write plainly, with unfading ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1803 Linden Ave
(c) Hospital or institution: Miller Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1803 Linden Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carrie R. Kay

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Charles Kay
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 18 1870

8. AGE: Years	Months	Days	If less than one day
75	0	28	hr. min.

9. Birthplace Pikesville Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business —

FATHER
12. Name Daniel Ditch
13. Birthplace Pikesville Md.

MOTHER
14. Maiden Name Rebecca (Unknown)
15. Birthplace -

16 (a) Informant John S. Ditch (Nephew)
(b) Address Columbia Rd, Ellicott City

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 12/19/45 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 DEC 17 1945 (Date rec'd by registrar) (Signature of registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 16th 1945, at 12 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1935, to Dec 16 1945, and that I last saw h[illegible] alive on Dec 15 1945

Immediate cause of death Cerebral Hemorrhage — Duration 1 week

Due to Arteriosclerosis — 20 yr.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward Dorsey, M. D.
Address 1011 W. Read St Date signed 12-17-45

VS 150

G35202

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1312

Registered No. G35202

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2506 N. Calvert st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2506 N. Calvert st (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Willard E. Hann

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Hannie M. Hann
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 9 1868

8. AGE: Years	Months	Days	If less than one day
77	6	6	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Builder
11. Industry or business Self

FATHER
12. Name Edwin W. Hann
13. Birthplace Md.

MOTHER
14. Maiden Name Edith L. Evans
15. Birthplace Va.

16 (a) Informant John E. Hann
(b) Address 4646 Marble Hall Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/18/45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location " Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul st.

DEC 17 1945 (Date accepted by local registrar) Huntingdon Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 15th 1945; at 11:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 14 1945 to Dec 15 1945 and that I last saw him alive on Dec 15 1945

Immediate cause of death

	Duration
Pneum. Myocarditis	1 day
Due to	
Due to	
Other conditions Arteriosclerosis Pneumonia	1 day

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C E Richardson
Address 1720 20th st Date signed Dec 17 45

VS 150

G35203 G35203

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PRINT IN WHITE PENCIL, WITH UNFADING INK

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4709 Harford Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 4709 Harford Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles A. Cummings

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6. (b) Name of husband or wife: Anna V. Cummings

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 18th 1862

8. AGE: Years 83 | Months 3 | Days 27 | If less than one day hr. min.

9. Birthplace Tylghmans Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Andrew Cummings

13. Birthplace Unknown

MOTHER 14. Maiden Name Martha Grace

15. Birthplace "

16 (a) Informant Anna V. Cummings (Wife)

(b) Address 4709 Harford Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/18/45 (month) (day) (year)

(c) Cemetery or crematory Mt. Olive

Location Roslyn Md.

18 (a) Funeral director William Cook Inc.

(b) Address 1217 St. Paul St.

DEC 17 1945 (Date received by Registrar) (b) Huntington Williams Registrar

VS 156

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 15th 1945, at 7.30 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 28 1945 to Dec 14 1945 and that I last saw him alive on Dec 14 1945.

	Duration
Immediate cause of death: Chronic myocarditis	
Due to: Myocardial Degeneration	10 years
Due to: Generalized arteriosclerosis (Senile)	
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. V. Harbold, M. D.

Address 4706 Harford Road Date signed 12/17/45

G35204 G35204

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 810 N Calvert St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town 810 N Calvert St
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Millie Virginia Lease

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) ~~Single, married~~, widowed, ~~or divorced~~ Widowed

6 (b) Name of husband or wife William T Lease

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 13, 1859

8. AGE: Years 86 | Months 6 | Days 2 | If less than one day hr. min.

9. Birthplace Frederick Md (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER 12. Name William Wenrich

13. Birthplace Frederick Md

MOTHER 14. Maiden Name Elizabeth White

15. Birthplace Frederick Md

16 (a) Informant Mrs. Minnie M. Hamper

(b) Address 810 N Calvert St

17 (a) Burial (Burial, cremation, removal) (b) Date thereof 12/18/45 (month) (day) (year)

(c) Cemetery or crematory Mt Olivet

Location Frederick Md

18 (a) Funeral director David R Martin

(b) Address Manchester Md

DEC 17 1945 (b)
(Date rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 15 1945 at 3:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 9 1945, to Dec 15 1945, and that I last saw h[illegible] alive on Dec 13 1945.

Immediate cause of death Bronchopneumonia

Due to

Due to

Other Conditions Myocarditis & general arteriosclerosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Hiram Hoyd M.D.

Address 1216 Medical Arts Date signed 12/22/45

Washington Williams, Registrar

107

635205

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. 635205

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 710 S Montford ave
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 710 S Montford ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Clara Slowikowski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 10 1899

8. AGE: Years 46 | Months 8 | Days 5 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joseph Slowikowski
13. Birthplace Poland

MOTHER
14. Maiden Name Rose Szulc
15. Birthplace Poland

16 (a) Informant Mrs Rose Slowikowski
(b) Address 710 S Montford ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-18-45 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Baltimore Md

18 (a) Funeral director George A Weber
(b) Address 705 S Ann st

19 (a) DEC 17 1945 (Date received by Registrar) (b) Huntington Williamsport Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 15 1945 at 12 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 3 1945 to Dec 15 1945 and that I last saw h[er] alive on Dec 14 1945

Immediate cause of death: Pulmonary Hemorrhage — Duration: 12 days
Due to: Pulmonary Tuberculosis — Duration: Unknown
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Clarence W. LeDoux M. D.
Address 601 S. Ellwood Ave. Date signed 12/15/45

G35206 ROMAN

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 91a

G35206 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address University Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 2616 E Baltimore (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs Mary Roman

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Frieson Roman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years 50 | Months | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business at Home

FATHER
12. Name Felix Szymanski
13. Birthplace Poland

MOTHER
14. Maiden Name ?
15. Birthplace Poland

16 (a) Informant Stefan Roman
(b) Address 2616 E Baltimore St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 20/45 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Baltimore

18 (a) Funeral director Greg W Olszewski
(b) Address 1830 Eastern Ave Huntingtown Williams, Md

19 DEC 17 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/16/45 19..., at M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/15 1945 to 12/16 1945 and that I last saw h[illegible] alive on 12/14 1945

Immediate cause of death: Pulmonary hemorrhage

Due to: [illegible]

Due to: acute internal [illegible]

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J R McHenry Jr M. D.
Address [illegible] Date signed 12-16-45

VS 180

G35207

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122B

Registered No. G35207

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 6 months

2. USUAL RESIDENCE OF DECEASED:
(a) Ward Bal (b) County
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 608 S. Paca St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alvin Scott

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
6 months	N	S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-10-45

8. AGE: Years	Months	Days	If less than one day
	6	3 4	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

MOTHER / FATHER

12. Name Josiah Scott

13. Birthplace Baltimore Md

14. Maiden Name Myrtle Lachen

15. Birthplace Baltimore Md

16 (a) Informant Mother

(b) Address 608 S. Paca St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-18-45 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn Ct

Location Balto City

18 (a) Funeral director David L. Brunston

(b) Address 108 W Montgomery St

DEC 17 1945 (Date rec'd by Local Registrar) (b) Hunting for Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-14 1945 at 4:25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-13 1945 to 12-14 1945 and that I last saw him alive on 12-14 1945

Immediate cause of death	Duration
Shock	
Due to Operation	
Due to Intestinal obstruction	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 12-13-45

Major findings of operation: Intussusception

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J Linthicum M. D.

Address 1514 Division St Date signed 12-14-45

G35208

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G35208

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1 Baltimore Maryland
(c) Hospital or institution: University Hospital 22
(d) Length of stay in hospital or inst. (yrs., mos., or days) d. d. a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 422 Druid Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lorraine Carter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 7 1941

8. AGE: Years 4 | Months 5 | Days 7 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER 12. Name Arthur Carter

13. Birthplace Baltimore Md

MOTHER 14. Maiden Name DRUHART Myrtle Ingulsby

15. Birthplace Baltimore Md

16 (a) Informant Arthur Carter

(b) Address 422 Druid Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/15/45 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Cy

Location A. G. Co. Md

18 (a) Funeral director Isaiah L. Brown Sr

(b) Address 1 Montgomery St

DEC 17 1945

19 (a) (Date rec'd by registrar) (b) Hattie J. Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 14, 1945, at 12:16 P.M.

21. I certify that I took charge of the remains described above, held an Inspection & Inquest thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Brain tumor

Due to

over

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Benedict Skiotarelis M.D. Medical Examiner.

Date signed December 14, 1945.

VS 151

Please type or print plainly. Physicians: please write the causes of death clearly and legibly.

G35209

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170 B Registered No. G35209

Please write the causes of death clearly and legibly. Correct age is especially important. Physicians: please write

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give name)
(d) Street No. 2822 E. Chase St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Morris Miller

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-05-4227

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Marie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1902

8. AGE: Years 43 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation at Guenther Brewery

11. Industry or business

FATHER 12. Name Louis Miller

13. Birthplace Russia

MOTHER 14. Maiden Name Sarah Markowitz

15. Birthplace Russia

16 (a) Informant Abraham Miller

(b) Address 7013 Edmondson ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/18/45 (month) (day) (year)

(c) Cemetery or crematory Hebrew Friendship

Location 3600 E Balto st

18 (a) Funeral director Sol Levinson & Bros

(b) Address 1126 N. North ave

19 DEC 17 1945 (Date rec'd by registrar) [illegible] Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 17, 1945 at 9 A. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
7 fractured Ribs, left. Diaphragmatic hernia

DUE to

Other Conditions Peritonitis Pericarditis
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 26-6

(a) Date of injury 12-10-45 at M.

(b) Where did injury occur O'Donnell & Allen Sts

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work?

(d) Means of injury Auto & Streetcar collision

23. Signature Benedict Skitarelic M.D. (Medical Examiner)

Date signed 12-17-45

G35210

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83B

Registration No. G35210

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1212 Oakhurst Place
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1212 Oakhurst Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME OLIVE S. SHIPLEY

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Ira W. Shipley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 6, 1877

8. AGE: Years	Months	Days	If less than one day
68	6	9	hr. min.

9. Birthplace A. A. Co., Md
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

MOTHER / FATHER
12. Name Charles F. Sappington
13. Birthplace A. A. Co., Md.
14. Maiden Name Mary Ann Wellham
15. Birthplace A. A. Co., Md.

16 (a) Informant Mrs. Edward G. Goeb
(b) Address 1212 Oakhurst Place

17 (a) Burial (b) Date thereof 12/18/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Friendship Cem.
Location A. A. Co., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 DEC 17 1945 Registrar

VS 150

MEDICAL CERTIFICATION P.

20. DATE OF DEATH Dec. 15, 1945, at 11:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1942 to Dec 15 1945 and that I last saw h alive on Dec 14 1945

Immediate cause of death

	Duration
Thrombosis - Cerebral Apoplexy	7 days
Due to Chronic Arterial Hypertension	
Due to	
Other Conditions Arteriosclerosis.	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Carroll Lockard M. D.
2925 N. Charles St. Address

635211

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 635211

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1812 Henneman Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1812 HennEman Ave
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Grace M. Campbell

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Grover C. Campbell
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct. 25-1900

8. AGE: Years	Months	Days	If less than one day
45	1	20	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Wm. Fischer
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Mary Biedenback
15. Birthplace Balto. Md.

16 (a) Informant Grover C. Campbell
(b) Address 1812 Henneman Ave.

17 (a) Burial (b) Date thereof Dec. 18/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem.
Location Eastern Ave.

18 (a) Funeral director John A. Miller
(b) Address 2334 Jefferson St.

19 (a) Date received by registrar DEC 17 1945 (b) Huntington Williams, M.D. Registrar

VS 6

MEDICAL CERTIFICATION

20. DATE OF DEATH 15 DEC 1945, at 12 50 P M

21. I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy find that said deceased came to her death on the day stated above.

Immediate cause of death Coronary occlusion — Duration
Due to —
Due to —
Other Conditions —
(Include pregnancy within 3 months of death)
Major findings:
Of operations —
Of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William J. Helfrich M.D.
Medical Examiner.
Date signed 15 DEC 45

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

635212

clinic

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. 635212

PRINT WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 230 N. Carey St.
(If rural give location)
(e) Citizen of foreign country? no. (Yes or No)
If yes, name country

3 (a) FULL NAME Patricia Anne Lewis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Fe	negro	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-9-45

8. AGE: Years	Months	Days	If less than one day
		1 day	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Lorenzo High
13. Birthplace Elizabethtown N.C.

MOTHER
14. Maiden Name Mollie Lewis
15. Birthplace Elizabethtown N.C.

16 (a) Informant Mollie Lewis
(b) Address 230 N. Carey St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School DEC 17 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 DEC 17 1945 (Signature of Registrar)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 - 9 - 1945, at 12 20 P.M

21. I certify that death occurred on the date above stated, that I attended deceased from 12-8 (12 noon) 1945, to 12-9 (7 P.M.) 1945, and that I last saw her alive on 12-9-1945.

Immediate cause of death	Duration
Due to Pneumonia	
Due to (Influenza)	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide S
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. S. Butler M. D.
Address Gunbst Hospital Date signed 12/17/45

3147

G35213
elmie

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G35213

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 621 Lafayette Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country No.

3 (a) FULL NAME Leroy Joseph Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-20-43

8. AGE: Years	Months	Days	If less than one day
		2 days	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Walter Washington
13. Birthplace W. Va

MOTHER
14. Maiden Name Annie Cross
15. Birthplace Gaylord Va.

16 (a) Informant Annie Smith
(b) Address 621 Lafayette Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location University Medical School DEC 17 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 DEC 17 1945 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-9 1945, at 5 45 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-20 1945 to 12-9-1945, and that I last saw him alive on 12-9-1945.

Immediate cause of death

Due to

Due to Pneumonia

Other Conditions (2 dy.)

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. D. Butler M. D.
Address Provident Hospital Date signed 12/14/45

3146

G35214

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G35214 Registered No.

Please write plainly, with unfading ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hosp. 11
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 13 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 4
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1035 N. Eutaw St.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Rosie Robinson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	Negro	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-5-45

8. AGE: Years	Months	Days	If less than one day
			13 hrs. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Lee Robinson
13. Birthplace Moulton N.C.

MOTHER
14. Maiden Name Rosie Williams
15. Birthplace Edgefield S.C.

16 (a) Informant Rosie Robinson
(b) Address 1035 N. Eutaw St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School DEC 17 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) DEC 17 1945 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-5 1945, at 1 45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-5-45 to 12-5-45, and that I last saw him alive on 12-5-45.

Immediate cause of death	Duration
Due to	
Due to Premature	
Other Conditions (None)	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature M. B. Butler M. D.
Address Provident Hospital Date signed 12/17/45

VS 150

3145

G35215 BALTIMORE CITY HEALTH DEPARTMENT 1945 G35215
CERTIFICATE OF DEATH Registered No.

Please write plainly, with unfading ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Ave.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 66 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2364 Wilkens Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Frederick Schwedes — Frederick Schwedes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Margaret Schwedes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 13, 1864

8. AGE: Years	Months	Days	If less than one day
81	11	5	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Storekeeper

FATHER
12. Name John George Schwedes
13. Birthplace Germany

MOTHER
14. Maiden Name Barbara Zaiss
15. Birthplace Germany

16 (a) Informant Mrs. Mamie Schwedes
(b) Address 2364 Wilkens Ave.

17 (a) Burial (b) Date thereof Dec. 18, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Cemetery
Location Woodlawn, Md.
18 (a) Funeral director Miller Lawrence
(b) 1005 N. Baltimore St.
19 (a) 7 1945 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/16 1945, at 9A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/7 1945 to 12/16 1945, and that I last saw h/ alive on 12/16 1945.

Immediate cause of death	Duration
Acute Heart Failure	
Due to Arterio-sclerotic Cardio-Vascular disease	
Due to	
Other Conditions Mild Pulmonary Edema	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Castleton T. Hall Jr.
Address St. Agnes Hosp. Date signed 12/16/45

VS 150

G35216

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G35216

Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly. PRESS WHITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 606 Perkins Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 606 Perkins Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Kate S. Campbell

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 26, 1865

8. AGE: Years	Months	Days	If less than one day
79	11	18	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name William L. Campbell
13. Birthplace Manchester, Md.

MOTHER
14. Maiden Name Rosina Carroll
15. Birthplace Baltimore, Md.

16 (a) Informant Miss C. A. Duvall
(b) Address 606 Perkins Ave.

17 (a) Burial (b) Date thereof Dec. 17, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Md.
18 (a) Funeral director Miles Funeral
(b) Address 1000 W. Baltimore St.
19 (a) (b)
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 14 1945 at 10 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 29 1945 to Dec 14 1945 and that I last saw h er alive on Dec 13 1945.

Immediate cause of death	Duration
Cardio Vascular disease	1 mo.
Due to Arteriosclerosis. -	few yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Wm Bowers and Hood M.D.
Address 2200 Garrison Ave. Date signed 12-15-45

Huntington Williams, M.D.

X

G35217

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G35217 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3919 Southern Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3919 Southern Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARIE LUERSSEN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Henry Luerssen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1st, 1879

8. AGE: Years	Months	Days	If less than one day
66	7	15	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George Lieber
13. Birthplace Germany

MOTHER
14. Maiden Name Christina Schock
15. Birthplace Germany

16 (a) Informant Mr. Henry Luerssen
(b) Address 2506 Taylor Ave.

17 (a) burial (b) Date thereof Dec. 19 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Immanuel Lutheran
Location Balto., Md.

18 (a) Funeral director Lanahan Funeral Home
(b) Address 7401 Belair Road

19 (a) 7 1945 (b) Registrar Williams
(Date of this registry)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 16, 1945, at 6:15PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-15 1945, to 12-16 1945, and that I last saw h[illegible] alive on 12-15 1945.

Immediate cause of death Cardio-Vasc Renal
Luerssen

Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature
Address 5707 Belair Rd Date signed 12-17-45

X

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35218 — BALTIMORE CITY HEALTH DEPARTMENT — G35218 Registered No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Dundalk (If outside city or town limits write RURAL and give town)
(d) Street No. 2710 Yorkway (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Carrol O.Smith ~~Earl C. Smith~~ (Carroll O.Smith)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Dorothy M. Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 31st 1904

8. AGE: Years: 41 | Months: 3 | Days: 16 | If less than one day: hr. min.

9. Birthplace: Baltimore Co, Maryland (Town, county, and state)

10. Usual Occupation: Guard

11. Industry or business: Western Electric

FATHER
12. Name: CHarles Louis Smith
13. Birthplace: Harford Co, Maryland

MOTHER
14. Maiden Name: Genevieve Eichelberger
15. Birthplace: Harford Co. Maryland

16 (a) Informant: Mrs. Carroll O. Smith
(b) Address: 2710 Yorkway Dundalk

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/19/45 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Baltimore, Maryland

18 (a) Funeral director: Lenahan Funeral Home
(b) Address: 7401 Belair Road

12-19-1945 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 16th 1945, at 1:35 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Hemothorax, bilateral

Due to: Fractured Sternum

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 27-5
(a) Date of injury 12-16-45 1:15 A.M.
(b) Where did injury occur? Belair Rd + Lorraine
(c) Did injury occur at home, on farm, industrial place, in public or private place? public While at work? no
(d) Means of injury: Auto struck safety pylon.

23. Signature: Benedict Skotarelis M.D. Medical Examiner.
Date signed 12-16-45

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. The

1 Female G35219

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G35219

correct age is especially important. Physicians: please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3040 W Garrison ave
(c) Hospital or institution: Balto Md
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto, Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 3040 W Garrison ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Rosa Emma McGowan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Wm D. McGowan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/5/1866

8. AGE: Years 79 | Months 2 | Days 11 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Home Duties

11. Industry or business Housework

FATHER
12. Name Wm Gage
13. Birthplace Hartford (New London)

MOTHER
14. Maiden Name Hannah Dorsey
15. Birthplace Calvert Co Md

16 (a) Informant Mrs Charles Hourd
(b) Address 3040 W. Garrison Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-19-45 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore, Md.

18 (a) Funeral director Sarring Byers
(b) Address 5005 Park Heights Ave

19 (a) (Date signed) (b) Registrar

DEC 19 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 16 1945, at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 13 1945 to Dec 16 1945 and that I last saw h alive on Dec 15 1945.

Immediate cause of death Cerebral Hemorrhage — Duration 3 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ed W. Euson M. D.
Address 7201 York Rd Date signed 12-16-45

X Balto 12 Md

G35620 — BALTIMORE CITY HEALTH DEPARTMENT — Registered No. G35620

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., ~~mos., or days~~) 3
(e) Length of stay in Baltimore (yrs., mos., or days) 3

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Broadway & Fairmount (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Fannie Bunbury

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 74 yrs.

8. AGE: Years	Months	Days	If less than one day
74 yrs			hr. min.

9. Birthplace Balto. Co. (Town, county, and state)

10. Usual Occupation

11. Industry or business —

FATHER 12. Name Andrew J. Bunbury
13. Birthplace Md.

MOTHER 14. Maiden Name M. E. Gardner
15. Birthplace Md.

16 (a) Informant Hosp. records.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-19-45 (month) (day) (year)
(c) Cemetery or crematory Cedarcroft M. E. Church
Location Reisterstown Rd.

18 (a) Funeral director Loring Rogers
(b) Address 5005 Park Heights Ave.

19 (a) DEC 17 1945 (Date received by Registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-12-1945, at 1:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-1-1945 to 12-12-1945 and that I last saw him alive on 12-12-1945

Immediate cause of death Coronary Thrombosis
Due to Fatty pneumonia
Due to
Other Conditions arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank M. Slaughter M. D.
Address Church Home & Hospital Date signed 12-14-45

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35221

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G35221 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1827 Orleans St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1827 Orleans
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cora Handy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	C.	Widowed

6 (b) Name of husband or wife Harrison

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 11th 1877

8. AGE: Years	Months	Days	If less than one day
68	5	3	hr. min.

9. Birthplace Washington D. C.
(Town, county, and State)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Dorothy Johnson
(b) Address 1827 Orleans St

17 (a) Burial (b) Date thereof 12-18-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Calvary
Location B. C. Co. Md.

18 (a) Funeral director Brantt Mayo & Wright
(b) Address 721 Dolphin St

19 (a) 12-17-1945 (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 14 1945 at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 13, 1945 to Dec 14 1945 and that I last saw he alive on Dec 14 1945.

Immediate cause of death	Duration
Acute Myocarditis	1 Day
Pulmonary edema	10 Day
Due to Bronchio Pneumonia	3 Days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. H. Lay Berry M.D.
Address 1420 E. Chase Date signed 12-17-45

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G353502 — BALTIMORE CITY HEALTH DEPARTMENT — G35[illegible]

CERTIFICATE OF DEATH

107

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 -5- 24
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1916 E. Fayette St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Fox

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June ? ? 187?

8. AGE: Years	Months	Days	If less than one day
73 ?	? 6	?	hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation Teking care of babies

11. Industry or business

FATHER
12. Name Theodore Fox
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Ruene
15. Birthplace Ireland

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation or removal) (b) Date thereof Dec. 18, 1945 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cathedral Cem.
Location Baltimore Md.

18 (a) Funeral director Geppi-Fleming
(b) Address 1426 Light St.

19 (a) [illegible] Hauling for Williams Mfg. Co.

DEC 18 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 16, 1945, at 6.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 22, 1945 to Dec. 16 1945, and that I last saw her alive on Dec. 16 1945

Immediate cause of death: a bronchopneumonia — Duration: 7.

Due to:

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation: none

of autopsy: Bronchopneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature T. P. Jernigan M. D.

Address Baltimore City Hall Date signed 12-17-45

X

Dr.T.J.Brennan G35223
5217 Harford Ave.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

✓ G35223 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4515 Mannasota Ave.
(c) Hospital or institution:
26
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 4515 Mannasota Ave.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Louis Matzen

3 (b) If veteran, name war	3 (c) Social Security Account No.
----------	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Amelia Johanna Matzen
6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) 1-15-1882

8. AGE: Years	Months	Days	If less than one day
63	11		hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation Brass Finisher
11. Industry or business

FATHER
12. Name John C. Matzen
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Amelia J. Matzen (Wife)
(b) Address 4515 Mannasota Ave.

17 (a) Burial (b) Date thereof Dec. 17, 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Schwartz
Location Baltimore Md.

18 (a) Funeral director Mamie Cook Lyfer
Address 1600 West North Ave.
DEC 18 1945 (b):
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 15 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-3 1945 to 11-9 1945; and that I last saw h.[illegible] alive on 11-9 1945.

Immediate cause of death	Duration
Cardiac failure	
Due to Coronary arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas Brennan M. D.
Address 5217 Harford Rd Date signed 12-17-45

VS 3

correct age is especially important. Physicians: please write the

G35224 ✓ G35224

BALTIMORE CITY HEALTH DEPARTMENT

G35224 CERTIFICATE OF DEATH 131a Registered No.

Every item of information should be carefully supplied. The age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1519 Filbert St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1519 Filbert St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Thresa Holler

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex F

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife John Holler

(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 6 1886

8. AGE: Years 59 Months 11 Days 11 If less than one day hr. min.

9. Birthplace Austria (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Rudolph Strangl

13. Birthplace Austria

MOTHER 14. Maiden Name unknown

15. Birthplace Austria

16 (a) Informant Clyde Mullins

(b) Address 1514 Filbert St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory Fullerton Cemetery

Location Allentown Pa

18 (a) Funeral director Sutton Schultz

(b) Address 3914 S. Hanover St

19 Date received by registrar DEC 18 1945 Wallace for William (1937) Registrar

VS 150

MEDICAL CERTIFICATION 1.5 Y.

20. DATE OF DEATH Dec 17 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 27 1945 to Dec 17 1945 and that I last saw her alive on Dec 14 1945

Immediate cause of death Uremia — Duration 1 day

Due to Myocardial Insufficiency — 9 mos.

Due to Hypertensive Vascular Disease — Long duration

Other Conditions Hypertension — Long Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Leon J. Horka M.D.

Address 700 Lemmington Date signed 12/17/45

G35225 ✓ G35225

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

Please write plainly, with unfading ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Pulaski
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 140 S Fremont
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Agnes Schenfele

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed or divorced Widowed

6 (b) Name of husband or wife George J

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 10 1892

8. AGE: Years	Months	Days	If less than one day
53	9	6 5	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Domestic Keeper

11. Industry or business Hospital

FATHER
12. Name Daniel Murphy
13. Birthplace Ireland

MOTHER
14. Maiden Name Elizabeth Murphy
15. Birthplace Ireland

16 (a) Informant Mrs. Agnes Schenfele
(b) Address 140 S Fremont St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-18-45 (Month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director George A Fahey
(b) Address Fulton & Fayette

19 (a) DEC 18 1945 (b) Huntington Williams Registrar
(Date rec'd by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/15/1945, at 7:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/14/1945, to 12/15/1945, and that I last saw h[illegible] alive on 12/15/1945.

Immediate cause of death	Duration
Coronary Thrombosis	8 Min.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature F. L. Michel Jr M. D.
Address Bon Secours Hosp. Date signed 12/15/45

Dr. Hickey
Northern G35226 & Belair

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 939

✓ G35226
Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5924 Kavon Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5924 Kavon Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clara Debes

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife ------
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 31, 1893

8. AGE: Years	Months	Days	If less than one day
52	3	15	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name John A. Debes
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary W. Hoenig
15. Birthplace Baltimore, Md.

16 (a) Informant Miss Catherine M. Debes
(b) Address 5924 Kavon Avenue -d-

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/18/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Leonard J. Buck
(b) Address 5305 Harford Road

19 (a) DEC 16 1945 (Date rec'd by registrar) (b) Baltimore, Md. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 15 1945 at 5 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 10 1945 to Dec 15 1945 and that I last saw him/her alive on Dec 14 1945

Immediate cause of death
Acute pulmonary edema — Duration: 1 day
Due to
Due to Chronic myocardial disease — ?
Other Conditions
Contributory arteriosclerosis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chas E Hickey M. D.
Address 1116 Northern Parkway Date signed 12/17/45

Hickey

Dr. Crooksfield
5402 Belair Rd.

G35227

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G35227

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRESS WHILE WRITING, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3811 Woodlea Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3811 Woodlea Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Peter Deering

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	widowed

6 (b) Name of husband or wife Emma A. Deering
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 16, 1861

8. AGE: Years	Months	Days	If less than one day
84	2	--	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mr. Clemence F. Deering
(b) Address 3811 Woodlea Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/14/45 (month) (day) (year)
(c) Cemetery or crematory German Cemetery
Location Washington Blvd, Maryland

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

DEC 18 1945
(a) (Date rec'd by registrar) (b) by Wm. Beamer

MEDICAL CERTIFICATION

20. DATE OF DEATH December 16 1945, at 2.50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-17 1935 to 12-16 1945.
and that I last saw h[illegible] alive on 12-16 1945.
Immediate cause of death Coronary Thrombosis
Duration
Due to
Due to Bronchial Pneumonia 1 dy
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature [illegible] Crooksfield
Address 5402 Belair Rd. Date signed 12-17-45

VS 150

G35228

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93a

G35228 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3512 W. Franklin St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) 56 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3512 W Franklin St.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Agnes S. Burger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married.

6 (b) Name of husband or wife George E. Burger, Sr.
6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) Dec. 30, 1888.

8. AGE: Years	Months	Days	If less than one day
56	11	15	hr. min.

9. Birthplace Baltimore, Maryland.
(Town, county and state)

10. Usual Occupation Home Wife.

11. Industry or business

FATHER
12. Name James E. Swain
13. Birthplace Baltimore. Md.

MOTHER
14. Maiden Name Annie Kinnear
15. Birthplace Maryland.

16 (a) Informant George E Burger Sr.
(b) Address 3512 W Franklin St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-18-45 (month) (day) (year)

(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director George L. Edwards
(b) Address 210 Fredericks Avenue
Catonsville, Md.

19 (a) DEC 18 1945 (b) Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 15 1945 at 2. PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1940 19 to Dec 15 1945 and that I last saw her alive on Dec 15 1945

Immediate cause of death Acute Myocarditis — Duration 1/12 yrs

Due to Arteriosclerosis and Hypertension — 10 yrs.

Due to Obesity — 20 yrs

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature O. W. Spurrier M.D.
Address 3603 Edmondson Ave Date signed Dec 16 1945
M. D.

O. W. Spurrier ×

TYPE OR WRITE WITH PERMANENT BLACK INK. Every item of information should be carefully supplied. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

G35229 | BALTIMORE CITY HEALTH DEPARTMENT ✓ G35229

CERTIFICATE OF DEATH 131a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 318 Millington Ave
(c) Hospital or institution: No

(d) Length of stay in hospital or inst. (yrs., mos., or days) No
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 318 Millington Ave.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Adelaide Virginia Lawson

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Henry J. Lawson
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 27, 1865

8. AGE: Years	Months	Days	If less than one day
80	6	19	hr. min.

9. Birthplace Westminster, Carroll County Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Charles G. Steffler
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Hibman
15. Birthplace Maryland

16 (a) Informant Goldie Mae Ewald
(b) Address 318 Millington Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-19-45 (month) (day) (year)
(c) Cemetery or crematory Deer Park
Location Deer Park Carroll County, Md.

18 (a) Funeral director Geo. L. Schaad
(b) Address 2401 Baldwin Avenue

19 (a) DEC 19 1945 (Date rec'd by registrar) (b) Huntingdon Pennsylvania

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 16, 1945, at 5:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 14 1945, to Dec 16 1945, and that I last saw him alive on Dec 15 1945.

Immediate cause of death: Pulmonary Edema

Due to: Hypertension

Due to: Hypertension, Mitral Insufficiency

Other Conditions: Chronic Nephritis

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert C. Hatch M. D.
Address 215 Walker Ave Date signed 12/17/45

92B

G35230

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G35230 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 322 S. Mount Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 322 S. Mount Street
(If no street give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Susan Ellen Simmons

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: George W. Simmons, Jr.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 21, 1879

8. AGE: Years 65 | Months 11 | Days 24 | If less than one day hr. min.

9. Birthplace Calvert County, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Charles R. Harris
13. Birthplace Maryland.

MOTHER
14. Maiden Name Alberta Beard
15. Birthplace Maryland

16 (a) Informant George W. Simmons, Jr.
(b) Address 322 S. Mount Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-20-45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director George L. Fahrwald
(b) Address 1724 Frederick Avenue

DEC 17 1945
(Date rec'd by registrar)

19 (a) (b) Hunting for William Smith

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH December 17, 1945; at 4:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 13 1945, to Dec 17 1945; and that I last saw her alive on Dec 17 1945

Immediate cause of death: Cerebral Hemorrhage — Duration: 24 hrs
Due to
Due to
Other Conditions: Carcinoma of Intestine.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert Scagnetti

Address 1724 Lombard Date signed Dec 17 '45 M. D.

Scagnetti X

G35231

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G35231

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 519 N. Curley St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 519 N. Curley St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wm J. Sheppard

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. widowed

6 (b) Name of husband or wife Nettie Sheppard

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 31-1867

8. AGE: Years 78 | Months 3 | Days 16 | If less than one day hr. min.

9. Birthplace Baltimore (town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER 12. Name J. W. Sheppard
13. Birthplace Baltimore

MOTHER 14. Maiden Name Caroline Davidson
15. Birthplace Baltimore

16 (a) Informant Mrs. Carrie Sterner
(b) Address 519 N. Curley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/18/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore

18 (a) Funeral director Philip Herrig Sons
(b) Address 2024 Orleans St.

DEC 18 1945 Walter for Williams U.P. (Date rec'd by registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 16 1945 at 2:20 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 9, 1945 to Dec 16 1945 and that I last saw h[illegible] alive on Dec 16 1945

Immediate cause of death
Uremia — Duration 7 days
Due to chronic nephritis — years
Due to arterio-sclerosis — years
Due to and hypertension — years

Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature Louis H. Kemmelman
Address 222 N. Kenwood Ave Date signed 12/17/45 (M. D.)

X

G35232

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G35232

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1617 N. Spring Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) 70 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1617 N. Spring Street
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Annie L. McMaines

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: William J. McMaines

6 (c) If alive, give age: D years

7. Birth date of deceased (mo., day, yr.): June 29th, 1871

8. AGE: Years 74 | Months 5 | Days 17 | If less than one day: ##### hr. min.

9. Birthplace: Ireland
(Town, county, and state)

10. Usual Occupation: At Home

11. Industry or business

FATHER
12. Name: Woolsey
13. Birthplace: Ireland

MOTHER
14. Maiden Name: Bridget Dunn
15. Birthplace: Ireland

16 (a) Informant: Mrs. Grace Murphy (Daughter)
(b) Address: 1617 N. Spring Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 12/19/45 (month) (day) (year)
(c) Cemetery or crematory: New Cathedral
Location: Edmondson Avenue

18 (a) Funeral director: George J. Ruth, Inc.
(b) Address: 1735 Harford Avenue

19 (a) (b) Date received by registrar: DEC 18 1945 Livingston Williams, Registrar

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 16 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/4 1944, to 12/16 1945
and that I last saw h/w alive on 12/14 1945

Immediate cause of death: Acute Coronary infarction — Duration

Due to: Hypertension

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. L. Hornstein M. D.
Address 733 Aisquith St Date signed 12/17

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35233

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

R G35233

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline Street
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1213 Aisquith St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter E. Garrettson ~~William Garrettson~~

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 16th, 1884

8. AGE: Years	Months	Days	If less than one day
61	11	0	###### min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Painter
11. Industry or business House

FATHER
12. Name George E. Garrettson
13. Birthplace Belair, Harford Co.

MOTHER
14. Maiden Name Georgiana Hanley
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Lilian A. Emmart (Sister)
(b) Address 528 E. 27th Street

17 (a) Burial (b) Date thereof 12/18/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Frederick Rd.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) DEC 18 1945 (b) Justin F. Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/16 1945, at 12:05 P.M.

21. I certify that I took charge of the remains described above, held an Inspection - Inquest and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Cerebral Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature R. J. Lubinski M.D.
Medical Examiner.
Date signed 12/17/45

X

Please write the causes of death clearly and legibly. Physicians: please write especially important.

G35234

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G35234

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 748 Denison St.,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 748 Denison St.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Gilbert Carr

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-12-3876

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Rosalie Carr

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 4, 1916

8. AGE: Years 29 | Months 8 | Days 11 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Produce Dealer

11. Industry or business

FATHER
12. Name Alex Carr
13. Birthplace Md.

MOTHER
14. Maiden Name Margaret B. ?
15. Birthplace Md.

16 (a) Informant Mrs. Rosalie Carr
(b) Address 748 Denison St.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-18-45 (month) (day) (year)
(c) Cemetery or crematory Meadowridge
Location Elkridge, Md.

18 (a) Funeral director G. Howard Strong
(b) Address 3207 W. North Ave.,

(c) DEC 18 1945 Registrar Planting for Philip Wagner

VS-150

MEDICAL CERTIFICATION 4.00

20. DATE OF DEATH Dec. 15, 1945 at A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1935 to Dec. 1945, and that I last saw h- alive on Dec. 1 1945.

Immediate cause of death Coronary Thrombosis — Duration ear. home

Due to —

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel L. Green M. D.

Address 1261 E. N. Ave. Date signed Dec 14, 45

Resident Obstetrics M.D.

G35235

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51 B

Registered No. G35235

PLEASE WRITE PLAINLY, with UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1434 Aisquith St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1434 Aisquith St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Harry W. Brown

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-07-9941

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 9th 1890

8. AGE: Years 55 | Months 7 | Days 8 6 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Tile Setter

11. Industry or business

FATHER
12. Name Timothy Brown
13. Birthplace Balto.

MOTHER
14. Maiden Name Ellen Martin
15. Birthplace Balto

16 (a) Informant Thomas Brown
(b) Address 1434 Aisquith St.

17 (a) Burial (b) Date thereof Dec 18, 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loraine
Location Balto

18 (a) Funeral director C. J. Fanning & Son
(b) Address 1938 Lafayette Ave.

19 (a) DEC 18 1945 Huntington Williams, M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 17 1945, at 12:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-24-45 19 to 12-15-45 19, and that I last saw h alive on 12-14-45 19.

Immediate cause of death Carcinoma of Prostate Gland — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John Constantine M.D.
Address 237 S. Conkling St Date signed 12-17-45

635236

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

635236
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Jenkins & Caton Aves.
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Catonsville (If outside city or town limits, write RURAL and give town)
(d) Street No. 507 Linden Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Robert Harrington

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Kate Emma J Whaley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1 30 62

8. AGE: Years 83 | Months 10 | Days 15 | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business B&O.

FATHER
12. Name Robert
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Joyce
15. Birthplace Ireland

16 (a) Informant Miss Rosalie Harrington
(b) Address 507 Linden Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/18/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3601 Frederick Rd

18 (a) Funeral director Harry H Wyatt
(b) Address 4101 Edmondson Ave.

19 (a) (Date rec'd by registrar) (b) Registrar
DEC 18 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/15 1945 at 6:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/23 1945 to 12/15 1945 and that I last saw h alive on 12/15 1945

Immediate cause of death Complete Heart Block

Due to Arteria - Sclerotic Cardio-vascular disease

Due to

Other Conditions Acute Vascular Hypotension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Custhus T. Hall Jr. M. D.
Address St. Agnes Hosp. Date signed 12/15/45

X

G35237

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G35237 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3706 Clifton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3706 Clifton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward E. Nordhoff

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widower

6 (b) Name of husband or wife Mary K.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 5, 1862

8. AGE: Years 83 | Months 2 | Days 10 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Watchmaker

FATHER 12. Name Amandus Nordhoff

13. Birthplace Germany

MOTHER 14. Maiden Name Martha Lohn

15. Birthplace Germany

16 (a) Informant Frederick C. Nordhoff

(b) Address 3706 Clifton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 18 1945 (month) (day) (year)

(c) Cemetery or crematory Loudon Pk.

Location 3801 Frederick Rd

18 (a) Funeral director Harry H. Wittle

(b) Address 4101 Edmondson Ave

19 (a) (Data rec'd by registrar) (b) Registrar

vs 188 DEC 18 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 15, 1945, at 11 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 6 1945, to Dec. 15 1945, and that I last saw him alive on Dec. 14 1945

Immediate cause of death: Cerebral hemorrhage & paralysis — Duration: 1 day

Due to:

Due to: Advanced arteriosclerosis — Duration: ?

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles D. Nuhlett M. D.

Address 2220 Harrison Blvd. Date signed Dec 18/45

635238 BALTIMORE CITY HEALTH DEPARTMENT ✓ 635238
CERTIFICATE OF DEATH 131a Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2917 Arunah Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2917 Arunah Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Matilda Wiedeck (Wiedeke)
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Henry Wiedeck
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) May 10, 1861
8. AGE: Years 84 | Months 7 | Days 5 | If less than one day hr. min.
9. Birthplace Germany (Town, county, and state)
10. Usual Occupation H. W.
11. Industry or business

FATHER
12. Name Frank Mielke
13. Birthplace Germany

MOTHER
14. Maiden Name —
15. Birthplace Germany

16 (a) Informant Frederick Wiedeck
(b) Address 2917 Arunah Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 19/45 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Annapolis Rd. a. G. Road
18 (a) Funeral director Harry H. Mielke
(b) Address 4101 Edmondson Ave.
19 (a) (Date rec'd by Registrar) (b) Registrar

DEC 18 1945 Printing for Baltimore, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 15/45, 19..., at ... M
21. I certify that death occurred on the date above stated; that I attended deceased from 11-4-45 1945 to 12-15-1945, and that I last saw her alive on 12-13-1945
Immediate cause of death Chronic cardio-renal disease
Due to Arteriosclerosis
Due to Senility
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration: Unknown

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. B. Seybert M. D.
Address 2802 Harford Rd. Date signed 12-17-45

G35239 | BALTIMORE CITY HEALTH DEPARTMENT | G35239

CERTIFICATE OF DEATH 937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1402 Ward st.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1402 Ward St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Johnson.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1873 - Sept. 4.

8. AGE: Years	Months	Days	If less than one day
72	3	9	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation None
11. Industry or business

FATHER
12. Name Frank Johnson.
13. Birthplace Md.

MOTHER
14. Maiden Name Henrietta Cooke.
15. Birthplace Annapolis, Md.

16 (a) Informant Mrs. Florence Mills.
(b) Address 804 Mc Kean Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 18 '45. (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial
Location

18 (a) Funeral director Mrs. Katie R. Williams.
(b) Address 322 N. Schroeder St.

19 (d) DEC 18 1945 Registrar
Registered by me this date by reading for Williams

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 13th 1945 at 8:30 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Shutarets M.D.
Medical Examiner.
Date signed 12-17-45

X

G35240

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 307

G35240 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied & correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green
(c) Hospital or institution: University 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 502 Vincent St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Davis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	W

6 (b) Name of husband or wife Arthur Davis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1898-6-12

8. AGE: Years	Months	Days	If less than one day
47	6	2	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name George Brown
13. Birthplace Md.

MOTHER
14. Maiden Name Rosa Mitchell
15. Birthplace Md.

16 (a) Informant Myrtle Parker
(b) Address 1538 N. Lexington St.

17 (a) Burial (b) Date thereof Dec. 18 '45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) (b)
(Date received by registrar)

DEC 18 1945

vs 15

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/14/1945 at 12 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/1/1945 to 12/14/1945 and that I last saw her alive on 12/14/1945.

Immediate cause of death Probable angina pectoris

Due to Senile Cerebritis

Due to Late Syphilis

Other Conditions

Duration

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph Anderson M. D.
Address University Hosp. Date signed 12/15/45

G35241

BALTIMORE CITY HEALTH DEPARTMENT ✓ 108

CERTIFICATE OF DEATH

G35241 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 807 N. Eden St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State ✓ Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 807 N. Eden St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Richard Henderson ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M. | 5. Color or race C. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Alice

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 22, 1903

8. AGE: Years	Months	Days	If less than one day
42	8	25	hr. min.

9. Birthplace Laurel, Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name James Henderson
13. Birthplace Md.

MOTHER
14. Maiden Name Mariah ?
15. Birthplace Md

16 (a) Informant Alice Henderson
(b) Address 807 N. Eden St.

17 (a) Burial (b) Date thereof 12/20/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location

18 (a) Funeral director Joseph E. Lehnert
(b) Address 1364 N. Central Ave

19 (a) DEC 18 1945 (b) Huntingtown, Williams, Md.
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/16 1945 at 8 30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 12 Dec 1945 to Dec 16 1945 and that I last saw him alive on Dec 16 1945

Immediate cause of death	Duration
Acute myocardial d.t.Tation	6 days
Due to Lobar Pneumonia	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. C. Burrell M. D.
Address 121 Augusta Date signed 12-17-45

X

G35242

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

935

Registered No. G35242

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3509 N. HILTON RD
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTO.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3509 N. HILTON RD
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SAMUEL LESSER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	WIDOW

6 (b) Name of husband or wife ETHEL

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years	Months	Days	If less than one day
70			hr. min.

9. Birthplace RUSSIA
(Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER
12. Name ABRAHAM
13. Birthplace RUSSIA

MOTHER
14. Maiden Name FANNIE
15. Birthplace RUSSIA

16 (a) Informant MRS. MONFREED
(b) Address 3509 N. HILTON RD

17 (a) BURIAL (b) Date thereof 12-18-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory BETH TFILOH
Location WINDSOR MILL RD

18 (a) Funeral director JACK LEWIS INC
(b) Address 1439 E. BALTO. ST

19 (a) (Date rec'd by Registrar) (b) Registrar

DEC 18 1945

Hunting for Northwest Jmk

MEDICAL CERTIFICATION 15

20. DATE OF DEATH 12-17-45 19 , at 10 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-1 1945 to 12-17 1945 and that I last saw h alive on 12-15 1945

Immediate cause of death Clin. card: vascular disease
Hypertension. Arteriosclerosis.

Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H Edmund Lewis

Address 3400 Hilton Rd Date signed 12/17/45

X

JOHN R. KUHN G35243

G35243

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 126

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden Ave
(c) Hospital or institution:
Maryland General Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 mos
(e) Length of stay in Baltimore (yrs., mos., or days) 54 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3708 Baker Street
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John R. Kuhn
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Rose Jane Kuhn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 13th 1869

8. AGE: Years 76 | Months 7 | Days 3 | If less than one day hr. min.

9. Birthplace Pennsylvania
(Town, county, and state)

10. Usual Occupation Retired.-

11. Industry or business

FATHER
12. Name Amos Kuhn
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Fannie Rife
15. Birthplace Pennsylvania

16 (a) Informant Dr. Esther F. Kuhn
(b) Address Rockville, Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 18-1945 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Baltimore Co. Md.

18 (a) Funeral director Burger Funeral Home
(b) Address 3631 Falls Road

19 (a) (Date rec'd by registrar) (b) Filed for Filing, MD

DEC 18 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH December 16th 1945, at 10.35 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 8- 1945, to Dec. 16 1945, and that I last saw h[illegible] alive on Dec. 16 1945

Immediate cause of death Terminal pneumonia — Duration

Due to Chronic Cerebrospinal Sclerosis and Cerebellitis with complete Heart Block. — Duration

Due to — Duration

Other Conditions Atypic cirrosis of liver. — Duration
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury C.E. GONZILEZ

23. Signature C. E. Gonzalez, M.D.
Address Maryland Gen. Hospital Date signed 12/16/45

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35244

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G35244

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 907 N. Saratoga St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 907 N. Saratoga St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maggie Bowman

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife Frederick

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 29, 1905

8. AGE: Years 40 | Months 4 | Days 17 | If less than one day hr. min.

9. Birthplace Lancaster Co. Va
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Andrew Smith
13. Birthplace Lancaster Co. Va.

MOTHER
14. Maiden Name Virginia Thompson
15. Birthplace Richmond Co. Va

16 (a) Informant Richard Smith
(b) Address 1609 N. Gilford St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 19, 19 (month) (day) (year)
(c) Cemetery or crematory Sebastian Mem. Park
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. Jas. H. Stafford
(b) Address 1631 Druid Hill Ave

DEC 18 1945
(Date rec'd by registrar)

(b) Hunting for Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 15 1945 at 8 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 4 1945 to Dec 15 1945 and that I last saw h[illegible] alive on Dec 15, 1945.

Immediate cause of death: Cerebral Apoplexy

	Duration
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D. J. Hutchins M. D.
Address 1726 Park Ave Date signed Dec 17 45

VS 150

G35245

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G35245 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1427 Mc Culloh st-17
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1427 Mc Culloh st - 17
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Mary F Shelton

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Edward Shelton

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-26-1890

8. AGE: Years 54 | Months 11 | Days 19 | If less than one day hr. min.

9. Birthplace Christiansburg Va
(Town, county, and state)

10. Usual Occupation Cook - Domestic

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Fanny Bolden
15. Birthplace Christiansburg Va

16 (a) Informant William H. Shelton
(b) Address 1427 Mc Culloh st - 17

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 19 1945 (month) (day) (year)
(c) Cemetery or crematory Shipped
Location Christiansburg Va

18 (a) Funeral director George T. Gibson
(b) Address 1736 Church Hill Ave - 17

19 (a) DEC 18 1945 (Date rec'd by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/15 1945, at 10a M

21. I certify that death occurred on the date above stated; that I attended deceased from 12.7 1945 to 12.15 1945, and that I last saw h. alive on 12.14 1945.

Immediate cause of death: Cerebral Apoplexy — Duration 24 hrs

Due to: Hypertension & Arteriosclerosis

Due to:

Other Conditions: La Grippe — 10 days

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
(f) Signature H P Leighton M. D.
Address 8 W N. Fremont Ave Date signed 12/17/45

VS 3

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

635246

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

635246 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1829 N. Milton Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1829 N. Milton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN G. LUBER

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-01-0446

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Fredericka M. Luber
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 7, 1870

8. AGE: Years	Months	Days	If less than one day
75 70	9	9	hr. min.

9. Birthplace Washington, D. C.
(Town, county, and state)
10. Usual Occupation Janitor
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs. J. G. Luber
(b) Address 1829 N. Milton Ave.

17 (a) burial (b) Date thereof Dec. 19, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore, Md.

18 (a) Funeral director Leasehold Funeral Home
(b) Address 7401 Belair Road

19 (a) (b)
(Date rec'd by registrar) Registrar

DEC 18 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH December 16, 1945, at 3:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-12-45 to 12-16-45
and that I last saw h[illegible] alive on 12-16-45

Immediate cause of death: Coronary Occlusion — Duration: 4 day
Due to: Cerebral Embolism
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. D.
Address Date signed

Awaiting for Williams, Md.

635247

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. 635247

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 4 T
(d) Length of stay in hospital or inst. (yrs., mos., or days) Doa.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 209 N. Pearl Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John H. BROWN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15, 1894

8. AGE: Years 51 | Months 7 | Days 2 | If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Market Salesman

11. Industry or business

FATHER
12. Name William A. Brown
13. Birthplace Baltimore

MOTHER
14. Maiden Name Betty J. Hartzell
15. Birthplace Baltimore

16 (a) Informant Mrs Stella M. Hanratty
(b) Address 1725 W. North ave.

17 (a) Burial (b) Date thereof 12-19-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto.

18 (a) Funeral director Frederick A. Poland
(b) Address 205 W. Lombard St

DEC 18 1945 (b) Baltimore, Md.
(Date received by Registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 17, 1945 at 10 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic pulmonary Tuberculosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Edward Co Gentzler M.D.
Medical Examiner.
Date signed Dec 19 1945

X

G35248

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170 C

G35248 Registered No.

write the causes of death clearly and legibly. Physicians: please write

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3213 Southern Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George W. Potter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Isabella C.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 20 - 1866

8. AGE: Years	Months	Days	If less than one day
79	5	26	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name ✓
13. Birthplace ✓

MOTHER
14. Maiden Name ✓
15. Birthplace ✓

16 (a) Informant Mrs. Helen Martin
(b) Address 3213 Southern Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-16-45 (month) (day) (year)
(c) Cemetery or crematory Holy Rd.
Location Balto

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Rd

DEC 18 1945 Hester E. Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 16th 1945, at 1 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Embolism

Due to Fracture of femur, Lft.

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12/4/45 at 27/2 5 25 A. M.
(b) Where did injury occur? Southern Ave & Hartford Rd
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no
(d) Means of injury Pedestrian struck by auto

23. Signature Benedict Sbrocchi M.D. Medical Examiner.
Date signed 12-16-45

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

635249

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 46E

635249

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison + Linden
(c) Hospital or institution:
Maryland General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ Mo
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Towson
(If outside city or town limits, write RURAL and give town)
(d) Street No. Shepard + Pratt Hospital
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dr. Arthur E. Pattrell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Nina G. Goudette
6 (c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) 8/27/1879

8. AGE: Years	Months	Days	If less than one day
< 66	3	20	hr. min.

9. Birthplace Vermont
(Town, county, and state)
10. Usual Occupation Physician
11. Industry or business —

FATHER
12. Name Oscar L. Pattrell
13. Birthplace Vt.

MOTHER
14. Maiden Name Eleanor Ellis
15. Birthplace Vt.

16 (a) Informant Nina E. Pattrell
(b) Address Shepherd Pratt

17 (a) Burial (b) Date thereof Dec. 20 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Union Fellowship Cemy.
Location Monroe St.

18 (a) Funeral director John O. Mitchell Sons
(b) Address 801 Eutaw Place

19 (a) DEC 18 1945 (b)
Date received by registrar Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/17 1945, at 3 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/25 1945 to 12/17 1945, and that I last saw him alive on 12/17 1945

Immediate cause of death	Duration
Generalized Metastases	
Due to Carcinoma of Sigmoid	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: None obtained
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Martin E. Stewart M. D.
Address Md. Genl. Hospital Date signed 12/19/45

Huntington Williams

X

G35250

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. G35259

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 727 Baker St
(c) Hospital or institution: none 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore city
(If outside city or town limits, write RURAL and give town)
(d) Street No. 727 Baker St
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Doretha Watkins

3 (b) If veteran, name war —

3 (c) Social Security Account No. none

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 30 1930

8. AGE: Years 15 | Months 1 | Days 16 | If less than one day ... hr. ... min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation School girl

11. Industry or business —

FATHER
12. Name Charles Watkins
13. Birthplace Maryland

MOTHER
14. Maiden Name Nannie Franklin
15. Birthplace Md

16 (a) Informant Nannie Watkins
(b) Address 727 Baker St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/19/45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. E. Kelly
(b) Address 1303 Pennsylvania Ave

DEC 18 1945 (Date rec'd by Registrar) (b) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 — 15 — 1945 at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-11 1945 to 12-15 1945 and that I last saw her alive on 12-14 1945

Immediate cause of death	Duration
Pulmonary Tuberculosis	30 days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Frank A Saunders M. D.
Address 1024 N. Stricker Date signed 12-16-45

VS 150

X

G35251

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. G35251

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2214 Mowis St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2214 Mowis St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clifton H. Johns

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10, 1902

8. AGE: Years	Months	Days	If less than one day
39	6	4	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name William H. Johns
13. Birthplace Md.

MOTHER
14. Maiden Name Stell Hammond
15. Birthplace Md.

16 (a) Informant Rose Duncan
(b) Address 2214 Mowis St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/18/45 (month) (day) (year)
(c) Cemetery or crematory Fair View
Location Fair View, Md.

18 (a) Funeral director Geo. G. Lelek
(b) Address 1303 Presbman St.

DEC 18 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-14-45 19..., at ... M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-10 1945 to 12-14 1945 and that I last saw h[illegible] alive on 12-14 1945.

Immediate cause of death Respiratory failure

	Duration
Due to Lobar Pneumonia	3 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Nature of injury

23. Signature Lyle E. Dawson M. D.
Address 2310 Madison Ave. Date signed 12-18-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35252

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47F

Registered No. G35252

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3007 Garrison Blvd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 58 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimores
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3007 Garrison Blvd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME David Hurwits

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Late Lena
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years	Months	Days	If less than one day
60			hr. min.

9. Birthplace Lith.
(Town, county, and state)
10. Usual Occupation
11. Industry or business Sheet Metal Worker

FATHER
12. Name Samuel Hurwits
13. Birthplace Lith.

MOTHER
14. Maiden Name Vera ?
15. Birthplace Lith.

16 (a) Informant Milton Howard
(b) Address 3007 Garrison Blvd

17 (a) Burial (b) Date thereof December 18, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Adas Israel Cemetery
Location North Point & German Hill Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) (b)
(Date received by Local Registrar) Registrar

DEC 18 1945 Arlington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 18, 1945 at 1 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1935 19 , to Dec 16 1945, and that I last saw h alive on Dec 16 19 45.

Immediate cause of death Cancer of Medistinum

Duration

Due to

Due to

Other Conditions Unrelated Heart

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. D.

Address 225 Linden Ave Date signed M.

X

G35253

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G35253 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 501 N. Calhoun St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 1
(e) Length of stay in Baltimore (yrs., mos., or days) 5yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 501 N. Calhoun St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Frances Washington

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: F | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: LARSON
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 6, 1882

8. AGE: Years	Months	Days	If less than one day
63	2	8	hr. min.

9. Birthplace Essex County, Va. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name James Bowler
13. Birthplace Essex County, Va.

MOTHER
14. Maiden Name Mary Meody
15. Birthplace Essex County, Va.

16 (a) Informant Cosby Washington (Son)
(b) Address 740 George St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/19/45 (month) (day) (year)
(c) Cemetery or crematory Angel Visit
Location Essex County, Va.

18 (a) Funeral director Charles G. Cooper
(b) Address 512 N Carrollton Ave.

19 (a) (Signature of registrar) (b) [illegible]

DEC 18 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 15 1945, at 10:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/17/45 to 12/15/45, and that I last saw h[illegible] alive on 12/15/45

Immediate cause of death: Arteriosclerosis Gangrene of right foot — Duration

Due to

Due to Hypertension

Other Significant Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 544 N. Carey St Date signed 12/17/45

G35254

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1/161a

G35254 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1729 E. Lombard St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1729 E Lombard Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby boy Ches

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days | If less than one day: hr. 5 min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business Infant

FATHER
12. Name Dolores C. Pierce
13. Birthplace Baltimore, 20, Md.

MOTHER
14. Maiden Name Bernard R. Ches.
15. Birthplace Baltimore 20, Md.

16 (a) Informant Dolores C. Ches
(b) Address 1729 E. Lombard Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 18 45 (month) (day) (year)
(c) Cemetery or crematory H. Rodgers
Location Balto. Md.

18 (a) Funeral director M. W. E. Disney & Son
(b) Address Baltimore & Ann St.

19 (a) DEC 18 1945 Registrar

VS 151

MEDICAL CERTIFICATION

30

20. DATE OF DEATH December 18 1945, at 11 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Res death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Atelectasis Neonatorum

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mullis M.D.
Medical Examiner.
Date signed 12-18-45

X

G35255

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G35255 Registered No. 11018

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3307 CLYDE ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3307 CLYDE ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BENJAMIN F. SCHEPLENG

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.:

4. Sex: MALE
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: SINGLE

6 (b) Name of husband or wife:
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOV. 26 1890

8. AGE: Years 55 | Months 11 | Days 20 | If less than one day hr. min.

9. Birthplace BALTIMORE MD. (Town, county, and state)

10. Usual Occupation CHIEF OF POLICE

11. Industry or business AT COPPER WORKS

FATHER
12. Name JOSEPH S. SCHEPLENG
13. Birthplace GERMANY

MOTHER
14. Maiden Name IDA MAYGERS
15. Birthplace BALTO. MD.

16 (a) Informant EDWARD SCHEPLENG (BROTHER)
(b) Address 1222 S. HIGHLAND AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof DEC. 19/45 (month) (day) (year)
(c) Cemetery or crematory OAK LAWN
Location EASTERN AVE. EXT.

18 (a) Funeral director Lilly & Zeiler Inc.
(b) Address 403 S. WOLFE ST.

19 (a) DEC 18 1945 (Date received by Registrar) (b) Registrar

VS.150

MEDICAL CERTIFICATION PM.

20. DATE OF DEATH DEC. 16 1945 at 5/30

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 13 1945 to Dec. 16 1945, and that I last saw him alive on Dec. 15 1945.

Immediate cause of death: Myocardial Insufficiency — Duration
Due to Chr. Nephritis — 2 yrs
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thos. E. Fulton M. D.
Address 3 W. Preston Signed 12-1-45

Hunting for Williams, M.D.

M. D. B. 1368-9

G35256 HEALTH DEPARTMENT—CITY OF BALTIMORE G35256

CERTIFICATE OF DEATH √112

1. PLACE OF DEATH 3520 Toone St. Registered No.

CITY OF BALTIMORE: (No. 19 St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. da. How long in U. S. If of foreign birth? yrs. mos. da.

2. FULL NAME Jessie G. Davis. V

(a) Residence: No. 3520 Toone St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

3a. If married, widowed, or divorced: HUSBAND of (or) WIFE of Thomas E. Davis

6. DATE OF BIRTH (month, day, year) July 12, 1890

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
55	5	6	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year) 12, 1945

11. Total time (years) spent in this occupation 39

12. BIRTHPLACE (city or town) (State or country) Virginia

FATHER

13. NAME Joseph Weymouth

14. BIRTHPLACE (city or town) (State or country) Va.

MOTHER

15. MAIDEN NAME Unknown

16. BIRTHPLACE (city or town) (State or country) Va.

17. INFORMANT Thomas Davis Hus.
(Address) 3520 Toone St.

18. BURIAL, CREMATION, OR REMOVAL
Place Mt. Carmel Date Dec. 20, 1945

19. UNDERTAKER Lally & Zeiler Inc.
(Address) 403 S. Wolfe St.

20. FILED 12-18-1945 Huntington Williams M.D. Registrar.

State CAUSE OF DEATH in plain terms. DO NOT USE TERMS OF MODE OF DYING, such as heart failure, asthenia, etc., without stating cause which produced them. Sudden death, cause unknown, must be certified as such. OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Decemb. 18, 1945

22. I HEREBY CERTIFY, That I attended deceased from December 16, 1945 to December 18, 1945

I last saw h[illegible] alive on Decemb. 17, 1945. Death is said to have occurred on the date stated above, at 1 a. m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Acute Myocardiac Insuffi-	
ciency	Unknown
Other contributory causes of importance: Chronic Asthmatic Bronchitis	1944

Name of operation None Date of

What test confirmed diagnosis? Hyst. Ex. Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? Date of injury 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury None

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) Joseph A. Rossblatt M. D.
(Address) 3018 O'Donnell St. 9a E

G35257

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G35257

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6000 Bellona Ave.
(c) Hospital or institution: Edgewood Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2007 E. Fenwick St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clara Emma Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Chas. A. Jones

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 11 1865

8. AGE: Years 80 | Months 11 | Days 5 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Wm. Brian
13. Birthplace Md.

MOTHER
14. Maiden Name Not Known
15. Birthplace

16 (a) Informant Chas E. Jones
(b) Address 2007 E. Lafayette Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 / 19 / 45 (month) (day) (year)

(c) Cemetery or crematory St. John's
Location Ellicott City, Md.

18 (a) Funeral director E. D. Lazenby & Son
(b) Address 1936 E. Fayette St. Funeral Home Baltimore, Md.

19 (a) 12-19-1945 (Filed by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 16 1945, at 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jany 4 1944 to Dec 16 1945 and that I last saw h[illegible] alive on Dec 16 1945.

Immediate cause of death: Cerebral Hemorrhage — Duration

Due to Arteriosclerosis

Due to Hypertensive Cardio-Vascular Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Howard Lauder
Address 1517 E North Ave Date signed 12/17/45

For Dr. J. R. Davis, By Howard J. Lauder, M.D.

G35258

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 87c

G35258 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 100 Ridgewood Road
(c) Hospital or institution: Roland Park
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 100 Ridgewood Road
(If rural give R.F.D.) Roland Park
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katharine M. Lyons

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
About 78			hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name John Lyons
13. Birthplace Ireland

MOTHER
14. Maiden Name Katharine Lloyd
15. Birthplace Ireland

16 (a) Informant Mr. Albert B. Hoen
(b) Address 100 Ridgewood Road Roland Park

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/19/45 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Meadows Son
(b) Address 805 N. Calvert Street

19 (a) DEC 18 1945 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 17 1945; at 7.00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1st 1945, to Dec 17th 1945, and that I last saw h.e alive on Dec 17th 1945.

Immediate cause of death
Parkinsons disease
Terminal Pneumonia
Due to Chronic Asthma
Due to
Other Conditions No

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy: No

Duration
6 yrs
1 week
1 yr

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. A. Stanford M. D.
Address 136 N. Calvert St. Date signed Dec 18 45

VS 150

21 X

G35259

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH √ 52a

G35259 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 34 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Penn. (b) County
(c) City or town Rockwood. (If outside city or town limits, write RURAL and give town)
(d) Street No. 652 W. Main St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country.

3 (a) FULL NAME Charles H. Schrock

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Hazel Schrock

6 (c) If dive, give age years

7. Birth date of deceased (mo., day, yr.) 1883 (62 yrs)

8. AGE: Years 62 | Months | Days | If less than one day hr. min.

9. Birthplace Pennsylvania (Town, county, and state)

10. Usual Occupation Water Station Repairman

11. Industry or business B & O Railroad

FATHER 12. Name John Shrock

13. Birthplace Pennsylvania

MOTHER 14. Maiden Name Annie Dunham

15. Birthplace Pennsylvania

16 (a) Informant Self.

(b) Address 652 W. Main St. Rockwood Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-21-45 (month) (day) (year)

(c) Cemetery or crematory Rockwood Pa

Location

18 (a) Funeral director Frank N Reamer

(b) Address Petersville Md.

DEC 18 1945 (Date received by registrar) (b)

Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/18 1945, at 6 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/14 1945 to 12/18 1945 and that I last saw h in alive on 12/18 1945

Immediate cause of death Cerebral Anemia — Duration

Due to Cerebral metastases

Due to Hypernephroma of Left Kidney

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 12/14/45

Major findings of operation: Hypernephroma Left Kidney

of autopsy: Not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature K.K. Clemmer M. D.

Address Univ. Hospital Date signed 12/18/45

Baltimore, Md X

X Director for Williams M.D.

G35260

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G35260
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Aves
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2½ D
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 343 S. Smallwood St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alexander F. Zimmerman

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-16-4422

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Clara Zimmerman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 5 1880

8. AGE: Years	Months	Days	If less than one day
65	11	11	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Theodore Zimmerman
13. Birthplace Balto. County

MOTHER
14. Maiden Name Amelia Eckert
15. Birthplace Balto. Md.

16 (a) Informant Selma Zimmerman
(b) Address 343 S Smallwood St

17 (a) Burial (b) Date thereof 12/20/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore Md.
18 (a) Funeral director J. B. Wagner Son
(b) Address 850 W. Baltimore St.
19 (a) (b)
(Date rec'd by registrar) Registrar

VS 150 DEC 18 1945 Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/16 1945, at 9:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/14 1945 to 12/16 1945; that I last saw him alive on 12/16 1945

Immediate cause of death	Duration
Respiratory failure	
Due to Uremia.	
Due to Arteriosclerotic & Hypertensive Cardiovascular Disease & Renal failure.	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Chas. E. Carroll
Address St. Agnes Hosp. Date signed M. 12 D. 16/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35261

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1108

Registered G35261

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Ave
(c) Hospital or institution: St. Agnes Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 412 Frederick Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Evelyn Hoard

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/29/1944

8. AGE: Years 1 | Months 1 | Days 18 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Walter G. Hoard
13. Birthplace Maryland

MOTHER 14. Maiden Name Estelle G. Keasler
15. Birthplace Maryland

16 (a) Informant Helen V. Hoard
(b) Address 412 Frederick Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/16/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park.
Location Baltimore, Md.

18 (a) Funeral director J. B. Kieffer & Son
(b) Address 450 W. Baltimore St.

19 (a) 12/18/45 (Date received by registrar)

VS 150 DEC 18 1945

Hunting for Hoard

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/16 1945, at 4:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/15 1945 to 12/16 1945 and that I last saw her alive on 12/16 1945

Immediate cause of death	Duration
Acute Cardio-Respiratory Failure.	
Due to Pneumonia - left upper and lower lobes.	
Due to	
Other Conditions Septicemia.	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Curtlenn T. Hall Jr. M. D.
Address St. Agnes Hosp. Date signed 12/16/45

X

G35262

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a G35262 MUENZING

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 309 S Fulton St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 309 S. Fulton
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sebastian Muenzing

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) March 30-1863

8. AGE: Years 82 | Months 9 | Days 17 | If less than one day ___ hr. ___ min.

9. Birthplace Philadelphia Pa
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Jacob H. Muenzing

13. Birthplace Germany

MOTHER 14. Maiden Name Barbara Mendler

15. Birthplace Germany.

16 (a) Informant John Muenzing

(b) Address 309 S. Fulton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/19/45 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Baltimore Md

18 (a) Funeral director F. J. Kippert Sons

(b) Address 856 W Baltimore St

19 (a) (Date received by registrar) (b) Registrar

DEC 18 1945 Huntington Millard

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 16 1945 at 7:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1945 to 12/16 1945 and that I last saw h alive on 12/15 1945

Immediate cause of death Coronary Thrombosis

Due to Hypostatic Pneumonia

Due to Internal Injuries

Other Conditions Senility

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
2 mos

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chas A Carlson M. D.

Address 2145 W Balto St Date signed 12/18/45

X

G35263

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92E

G35263 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2727 Beryl Ave
(c) Hospital or institution: Res.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2727 Beryl
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) **FULL NAME** Lewis C. Eder

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Rosina

6 (c) If alive, give age DEAD years

7. Birth date of deceased (mo., day, yr.) August 2 1883

8. AGE: Years 62 | Months 8 4 | Days 13 | If less than one day ____ hr. ____ min.

9. Birthplace Passau Bavaria Germany
(Town, county, and state)

10. Usual Occupation Store Owner

11. Industry or business Grocery

FATHER
12. Name Carl Eder
13. Birthplace Germany

MOTHER
14. Maiden Name Theresa Schmeizel
15. Birthplace Germany

16 (a) Informant (Son) Alex Eder
(b) Address 2727 Beryl Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 16 1945 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Moravia And Belair RD.

18 (a) Funeral director Joseph Dellaluce
(b) Address 52 N Morley Ave

DEC 18 1945 (Date received by registrar) (Signature) for Williams M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 15 1945, at 3 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1944 to Dec 15 1945 and that I last saw him alive on Dec 15 1945

Immediate cause of death: Coronary Thrombosis — Duration: 10 hrs.

Due to: Chronic Endo-myocarditis — 15 yrs.

Due to:

Other Conditions: Generalized Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Frank J. Ayd M. D.
Address 2005 E Monument St Date signed 12/17/45

635264

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

635264
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1206 E. 36th St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1206 E 36th St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Loretta D. Connolly

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) ~~Single~~, married, ~~widowed~~, or ~~divorced~~ Married

6 (b) Name of ~~husband~~ or wife Paul R.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 23 1897

8. AGE: Years 48 | Months | Days 22 | If less than one day ... hr. ... min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John J. Barry
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Margaret A Kane
15. Birthplace Baltimore Md

16 (a) Informant Martin J Barry
(b) Address 4 E 39th St

17 (a) Burial (b) Date thereof Dec 18 45
(Burial, cremation, or removal) (month) (year)

(c) Cemetery or crematory New Cath
Location Old Frederick Rd.

18 (a) Funeral director John A. Hogan
(b) Address 300 E. Baltimore St.

19 (a) ... (b) ...
(Date received by Registrar) DEC 18 1945 Huntington Williams, M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 15 1945; at ... M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 10 1945 to 12-15 1945, and that I last saw h[illegible] alive on 12-15 1945.

Immediate cause of death Coronary occlusion — Duration ...

Due to ...

Due to ...

Other Conditions ...

(Include pregnancy within 3 months of death)

Date of operation ...

Major findings of operation: ...

of autopsy: ...

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ...
(b) Date of occurrence ... at ... M
(c) Where did injury occur? ...
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ... While at work? ...
(Specify type of place)
(e) Means of injury ...

23. Signature Mary Dunn M. D.
Address Med Arts Date signed 12-17-45

X

G35265

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93a

Registered No. G35265

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1106 Druid Hill Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1106 Druid Hill Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARTHA ELLEN COLE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 18, 1862

8. AGE: Years	Months	Days	If less than one day
82	11	28	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Perry Brown
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Gilmor
15. Birthplace Md.

16 (a) Informant Mrs. Mamie Webster
(b) Address 2311 Hunter St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-20-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) Dec 18 1945 Huntington Wilkinson

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 16, 1945 at 9A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 6 1945 to Dec 16 1945 and that I last saw h alive on Dec 16 1945

Immediate cause of death	Duration
acute Myocarditis	
Due to Old age	7 d.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edmund L. Wheeler M. D.
Address 1220 Druid Hill Ave Date signed Dec 19 45

X

G35266

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 67

G35266

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 36 South Eden Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rose Anna Fowler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/25/45

8. AGE: Years | Months 3 | Days 24 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name William Fowler
13. Birthplace Raleigh N.C.

MOTHER
14. Maiden Name Beatrice Robinson
15. Birthplace Raleigh, N.C.

16 (a) Informant Beatrice Fowler
(b) Address 36 South Eden St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 19 45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Brooklyn Md.

18 (a) Funeral director Mrs. Ida Bailey
(b) Address 1421 E. Jefferson St.

19 (a) Dec 18 1945 (b) [illegible] Registrar
Date received by registrar

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH December 18, 1945, at 9 A. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Scurvy

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury, at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D. Medical Examiner.
Date signed Dec. 18 1945

G35267

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G35267

HB # 90757

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo. 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 17 Years

17

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 702 Pennsylvania Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Stewart

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	C	Separated

6 (b) Name of husband or wife Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 19, 1899

8. AGE: Years	Months	Days	If less than one day
46	9	19	hr. min.

9. Birthplace North Carolina
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Colondus Stewart(d)
13. Birthplace N.C.

MOTHER
14. Maiden Name Quennie Sweat(d)
15. Birthplace N.C.

16 (a) Informant Balto. City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location University Medical School DEC 18 1945

18 (a) Funeral director Commissioner of Health

(b) Address

DEC 18 1945 (Date rec'd by registrar) Clerk for Williams M.D.

VS 150

3151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 8, 1945, at 9:40A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 20, 1944 to Dec. 8, 1945 and that I last saw him alive on Dec. 8, 1945.

Immediate cause of death Pulmonary Tuberculosis Tuberculous Enteritis — Duration ?

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herbert B. Copeland Jr. M.D.
Address Balt. City Hosp. Date signed 12/15/45

G35268

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161C

G35268 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Hosp. for Women of Md. 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. 17
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1118 N. Monroe St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Richard Eugene Rider

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/12/45

8. AGE: Years | Months | Days 3. | If less than one day hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name John Tolbert Rider.
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Sarah McCormick
15. Birthplace Alexandria, Va.

16 (a) Informant Sarah Rider
(b) Address 1118 N. Monroe St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School DEC 18 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) DEC 18 1945 (c'd by registrar) Washington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/15 1945, at 4:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/12 1945 to 12/15 1945, and that I last saw him alive on 12/15 1945.

Immediate cause of death Hemorrhage from Kidney — Duration 12 hrs.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Hemorrhage Kidney - Rt.

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Elizabeth Acton, M.D. M. D.
Address Date signed

VR 150

3150

X

635269

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157a

Registered No. 635269

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Towson
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1611 Dartford Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Sasser

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-10-45

8. AGE: Years | Months | Days | If less than one day: 12 hrs. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Jesse. Sasser
13. Birthplace

MOTHER
14. Maiden Name Mamie
15. Birthplace

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Hospital DEC 17 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 DEC 18 1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION A

20. DATE OF DEATH Dec. 11 1945, at 4:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 10 1945, to Dec. 11 1945, and that I last saw him alive on Dec. 11 1945.

Immediate cause of death	Duration
Respiratory failure	
Due to Multiple congenital anomalies	
Due to Hydrocephalus, meningomyelocele, club feet	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. H. Mortimer, Jr. M. D.
Address Johns Hopkins Date signed 12/11/45

VS 150

3149

635270

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157 M

Registered No. 635270

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: The Johns Hopkins Hospital 31
(d) Length of stay in hospital or inst. (yrs., mos., or days) 34 days
(e) Length of stay in Baltimore (yrs., mos., or days) 34 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1416 E. Lombard Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Ellen McFadden

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 9, 1945

8. AGE: Years	Months	Days	If less than one day
	1	34	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Eugene Mc Fadden
13. Birthplace Virginia

MOTHER
14. Maiden Name Ellen Rush
15. Birthplace Virginia

16 (a) Informant Hospital Records
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School DEC 18 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 13 1945, at 12 [illegible]

21. I certify that death occurred on the date above stated; that I attended deceased from November 9 1945, to December 13 1945, and that I last saw her alive on December 13 45.

Immediate cause of death	Duration
1 Pneumonia	
2 Septicemia	
Due to 1 congenital absence of right lung	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Gilbert J. Valburgh M. D.
Address Johns Hopkins Hospital Date signed

VS 150

3153

G35271

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161c

Registered No. G35271

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: The Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Charles
(c) City or town Hughesville (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph Richard Hartman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 14, 1945

8. AGE: Years	Months	Days	If less than one day
		4	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Richard Hartman
13. Birthplace Minnesota

MOTHER
14. Maiden Name Leona Gruss
15. Birthplace Maryland

16 (a) Informant Hospital Records
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School DEC 18 1945

18 (a) Funeral director Commissioner of Health
(b) Address

DEC 18 1945 (Date rec'd by registrar) (By) Williams, M.D. Registrar

5152

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 18 1945, at 3:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from November 14 1945, to November 18 1945, and that I last saw him alive on November 18 1945.

Immediate cause of death erythroblastosis fetalis
? pneumonia — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Gilbert J. Vosburgh. M. D.
Address Johns Hopkins Hosp. Date signed 11-19-45

X —

Dr. Levy

~~601 Rutland~~ 635272

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183

635272 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 607 N. Rose Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 607 N. Rose Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Joseph Savorski

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Ellen M. Savorski
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 1, 1878

8. AGE: Years	Months	Days	If less than one day
67	--	14	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Esskay
11. Industry or business

FATHER
12. Name George Zavorski
13. Birthplace Poland

MOTHER
14. Maiden Name Frances Zavorski
15. Birthplace Poland

16 (a) Informant Mrs. Ellen M. Savorski
(b) Address 607 N. Rose Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/18/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) 18 1945 (Date rec'd by registrar) by Washington Williamsburg

MEDICAL CERTIFICATION

20. DATE OF DEATH December 15, 1945, at 9P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 21 1945 to Dec. 15 1945 and that I last saw h[illegible] alive on Dec. 11 1945.

Immediate cause of death: Bronchio-Pneumonia (Terminal) — Duration: 4 days
Due to: Anemia — 4 mos.
Due to: Cerebral Thrombosis — 8 mos.
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ernest Levy M.D.
Address 1001 N. Broadway Date signed 12/16/45

VS 150

FILL WHITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

G35273

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

116a

G35273 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 729 Cator Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 729 Cator Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James W. McGill

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Sallie McGill
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 15, 1856

8. AGE: Years	Months	Days	If less than one day
89	9	1	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Thomas F. McGill
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Emily Bowdle
15. Birthplace ?

16 (a) Informant Miss Sadie McGill
(b) Address 729 Cator Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/19/1945 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location A. A. Co. Md.

18 (a) Funeral director Flynn & Fleming
(b) Address 1426 Light Street

19 (a) DEC 18 1945 (Date received by registrar) (b) Thurlington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 16 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/12 1945 to 12/16 1945; and that I last saw him alive on 12/16 1945.

Immediate cause of death	Duration
(a) Myocardial insufficiency.	5 days.
Due to	
Due to (b) Coma	
Other Conditions Acute bronchitis	3 days.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature J. W. Grayton
Address 3963 Greenmount Ave. Date signed 12/18/45.

VS 150

X

G35274 ✓ G35274

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 106 N Gruno St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 106 N Gruno St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ella N. Stratton

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: James M. Stratton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Sept 8 1858

8. AGE: Years 87 | Months 3 | Days 15 | If less than one day hr. min.

9. Birthplace Blairsville Pa
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Joseph Atkinson
13. Birthplace Unknown

MOTHER
14. Maiden Name Elizabeth Wilson
15. Birthplace Ky

16 (a) Informant Mrs Margaret Kitchelter
(b) Address 106 N Gruno St

17 (a) Removal (b) Date thereof 12/20/45
(Burial or cremation or removal) (month) (day) (year)
(c) Cemetery or crematory Blairsville
Location Pa.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) (Date rec'd by registrar) (b) Huntingdon Williamsport Pa (Registrar)

DEC 19 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 18 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 16 1945 to 19 , and that I last saw h alive on Dec 17 1945

Immediate cause of death	Duration
Acute Cardiac Dilitation	Ans day
Due to Hypertensive Cardio Vascular Disease	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry Glassman M. D.
Address 2683 Mei Lane Date signed Dec 18 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35275

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G35275 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3108 N Calvert St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3108 N Calvert St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Newton Otis Jr

3 (b) If veteran, name war W | 3 (c) Social Security Account No. none

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Margaret Cameron
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 12 1864

8. AGE: Years 78 | Months 4 | Days 6 | If less than one day hr. min.

9. Birthplace Staunton, Va (Town, county, and state)

10. Usual Occupation Manufacturer

11. Industry or business Oil Business

FATHER
12. Name John Newton Otis
13. Birthplace Staunton Va

MOTHER
14. Maiden Name Isabella Harmon
15. Birthplace Va

16 (a) Informant Mrs A B Lofty
(b) Address 921 S St Joseph St

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 12/19/45 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Baltimore Md

18 (a) Funeral director Tilbom Corbin
(b) Address 1217 St Paul St

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 18 1945 at 5:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1940 to Dec 18 1945 and that I last saw him alive on Dec 17 1945

Immediate cause of death (a) Cerebral Embolism

Due to Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration
(a) 4 years
7 years

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herbert M. Foxley M.D.
Address 2824 St. Paul St Date signed 12/19/45

EC 19 VS 150 45

Huntington Williams, MD

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G35276 10 G35476

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Harford Rd. at Herring Run
(c) Hospital or institution: Sydenham Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Frederick
(c) City or town Emmitsburg
(If outside city or town limits, write RURAL and give town)
(d) Street No. —
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary I Wagerman

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct. 16th, 1935

8. AGE: Years	Months	Days	If less than one day
10	2	2	____ hr. ____ min.

9. Birthplace Emmitsburg, Frederick, Md.
(Town, county, and state)
10. Usual Occupation Schoolchild
11. Industry or business —

FATHER
12. Name John Wagerman
13. Birthplace Emmitsburg, Md.

MOTHER
14. Maiden Name Edith Brawner
15. Birthplace Emmitsburg, Md.

16 (a) Informant Mother
(b) Address Emmitsburg, Md.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 12/19/45 (month) (day) (year)
(c) Cemetery or crematory Emmitsburg
Location Emmitsburg, Md.

18 (a) Funeral director William Rock Inc
(b) Address 1217 Eutaw St

19 (a) DEC 19 1945 (b) Registrar
(Date rec'd by registrar)
Huntingtown Hillcrest Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 18th, 1945, at 12:55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 15th, 1945, to Dec. 18th, 1945, and that I last saw her alive on Dec. 18th, 1945.

Immediate cause of death	Duration
Heart failure	
Due to Complete heart block	
Due to Diphtheria	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: ✓

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Adelphia Groggins M.D.
Address Sydenham Hosp. Date signed 12-18-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35277 ✓ G35277

JL - 7699

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 - 5- 26
(e) Length of stay in Baltimore (yrs., mos., or days) 47 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1821 E. North Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Rutley

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
W	none	Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 31, 1872

8. AGE: Years	Months	Days	If less than one day
73 72	8	16 17	hr. min.

9. Birthplace England (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Thomas Rutley
13. Birthplace England

MOTHER
14. Maiden Name Patrica Roberts
15. Birthplace England

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 19, 1945 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore, Md.

18 (a) Funeral director Williams Cook, Inc.
(b) Address 1317 St. Paul St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

DEC 19 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 17 1945, at 2.25PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 21 1945, to Dec. 17 1945, and that I last saw h. alive on Dec. 17 1945

Immediate cause of death: Coronary occlusion — Duration: 24hrs

Due to: Arteriosclerotic cardio vascular disease — Duration: 7

Due to — Duration:

Other Conditions: Fract. of L. femur intertrochanteric — Duration: 3 mo.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 26/12
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 9/3/45 at 2 PM
(c) Where did injury occur? Baltimore (City or town) Md (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Infirmary (Specify type of place) While at work? no
(e) Means of injury Fell down hall to floor

23. Signature B.C.H. M. D.
Address Date signed 12/19/45

To be approved by Medical Examiner Thomas J. Williams, M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35278

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52a

G35278 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2113 E Baltimore St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2113 E Baltimore St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rebecca Rosen

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Late William
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years	Months	Days	If less than one day
58			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation
11. Industry or business House Work

FATHER
12. Name Unkown
13. Birthplace Russia

MOTHER
14. Maiden Name Unkown
15. Birthplace Russia

16 (a) Informant Joseph Berman
(b) Address 4914 Queensbury Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof December 19, 1945 (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cem
Location Hamilton Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) (Signature of Registrar) (b) Huntington Williams

DEC 19 1945

MEDICAL CERTIFICATION 11.00

20. DATE OF DEATH December 18 1945, at 4. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 3, 1945 to Dec 18, 1945; and that I last saw her alive on Dec 17, 1945.

Immediate cause of death Uremic Coma — Duration About one year.

Due to Hypernephroma and Metastases.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
1945
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Hallsant Spirt M.D. M. D.
Address 1810 Eutaw Pl. Date signed 12/18/45

VS 150

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35279 ✓ G35279

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution: Monument & Rutland Ave
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-7
(e) Length of stay in Baltimore (yrs., mos., or days) 41 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3205 Vickers Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joel David Goldman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Helen Nee Levy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 5, 1893

8. AGE: Years	Months	Days	If less than one day
52		13	hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation
11. Industry or business Merchant

FATHER
12. Name Ididore Goldman
13. Birthplace Russia

MOTHER
14. Maiden Name Sarah M Jacobs
15. Birthplace Russia

16 (a) Informant Harry Goldman
(b) Address 3205 Vickers Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec, 19, 1945 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship Cem
Location E Baltimore St 5600

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150 DEC 19 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/18/45 1945, at 945 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 4 1945, to Dec 18 1945, and that I last saw h— alive on Dec 18 1945.

Immediate cause of death	Duration
Myocardial infarction due to	
Coronary thrombosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy: Myocardial infarction

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Morris Rubin M. D.
Address Sinai Hosp Date signed 12/19/45

X

G35280

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G35280 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1205 N. Linwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits write RURAL and give town)
(d) Street No. 1205 N. Linwood Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Edna Susan Gaghen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: John Gaghen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 16, 1892

8. AGE: Years	Months	Days	If less than one day
53	—	1	hr. min.

9. Birthplace Allentown, Pa.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Nathan Zinger
13. Birthplace Allentown Pa

MOTHER
14. Maiden Name Catherine Rott
15. Birthplace Allentown Pa

16 (a) Informant Marian Gaghen - light
(b) Address 1205 N. Linwood Ave

17 (a) removal (b) Date thereof 12/19/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or ~~crematory~~ Fairview Cemetery
Location Allentown Pa

18 (a) Funeral director Clayton E. Lehmond
(b) Address 1601 E. Madison St

19 (a) DEC 19 1945 Huntington Williams MD
(Date received by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 17, 1945, at 9:40 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Coronary Thrombosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial-place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Naterchia M.D.
Medical Examiner.
Date signed December 18, 1945.

G35281

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G35281

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2810 Ashland Ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Frank J Cavanaugh, Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-05-7161

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Margaret
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 18, 1889

8. AGE: Years	Months	Days	If less than one day
56 yrs,	1	27	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business Wetzler's

FATHER
12. Name Frank Cavanaugh
13. Birthplace Baltimcre, Md.

MOTHER
14. Maiden Name Margaret Zorbach
15. Birthplace Baltimcre, Md.

16 (a) Informant Mrs. Margaret Cavanaugh-wife
(b) Address 2810 Ashland Avenue JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/19/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Rose St. & North Ave. Balto. Md

18 (a) Funeral director Charles E. Schimunek
(b) Address 2001-03 E. Madison St.

(a) DEC 19 1945 (Date received by Registrar) Harrington for Williams M.E. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 15 1945, at 4 30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-15 1945, to 12-15 1945, and that I last saw h alive on 12-15 1945

Immediate cause of death	Duration
Cardiac Failure	
Due to Cerebral hemorrhage	
Due to	
Other Conditions High blood pressure	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Massive pontine hemorrhage

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry Wirt Rollins
Address Johns Hopkins Hosp Date signed 12-15-45

VS 150

G35282

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G35282

170c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Annapolis (If outside city or town limits, write RURAL and give town)
(d) Street No. Best gate (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Shirley Moreland

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: Singe

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 1- 35

8. AGE: Years: 10 | Months | Days: 15 17 | If less than one day: hr. min.

9. Birthplace a A Co. Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Gordon R. Moreland
13. Birthplace a A Co Md.

MOTHER 14. Maiden Name Hilda M Bowie
15. Birthplace a. A Co Md.

16 (a) Informant Gordon R. Moreland
(b) Address Best Gate AA. Co

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/21/45 (month) (day) (year)
(c) Cemetery or crematory Edwards Chapel
Location Annapolis Md.

18 (a) Funeral director E W. Lamorgan
(b) Address 4510 Liberty Hgts Ave

DEC 19 1945 (Date received by local reg.) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 18 - 1945, at 6 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Skull fracture
Intracranial hemorrhage
Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12/12/45 9 P M.
(b) Where did injury occur? Annapolis
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no
(d) Means of injury Struck by auto.

23. Signature Benedict Skaralis M.D. Medical Examiner.
Date signed 12-19-45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35283

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G35283

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 1/2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(b) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(c) Street No. 1838 North Chapel (If rural give location) 1838
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary McCart

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife ANDREW JOHN

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 6-1885

8. AGE: Years 60 | Months 8 | Days 11 | If less than one day hr. min.

9. Birthplace BALTO. (Town, county, and state)

10. Usual Occupation HOUSE WIFE

11. Industry or business

FATHER
12. Name MICHEL J. McCUSKLEY
13. Birthplace IRELAND

MOTHER
14. Maiden Name ANNIE E. HEALY
15. Birthplace IRELAND

16 (a) Informant MARY A. McGROGAN
(b) Address 2403 BRENDON AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12-21-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem
Location Balto Md.

18 (a) Funeral director Jos. J. Kerr & Son
(b) Address 3001 Kentucky Ave.

19 (a) DEC 19 1945 (Registrar's signature) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/18/45 19 at 8:20 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive Cardio Renal Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis M.D.
Medical Examiner.
Date signed 12/18/45

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

G35284 **CERTIFICATE OF DEATH** 83a Registered G35284

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3407 W. Franklin St.
(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3407 W. Franklin Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Doris A. Jones

3 (b) If veteran, name war ---

3 (c) Social Security Account No. 213-20-6371

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Milton L. Jones
6 (c) If alive, give age 23 years

7. Birth date of deceased (mo., day, yr.) Jan. 16, 1924

8. AGE: Years	Months	Days	If less than one day
21	11	1	...hr. ...min.

9. Birthplace: Balto. Md.
(Town, county, and state)

10. Usual Occupation: House-wife

11. Industry or business

FATHER
12. Name: Harry C. Grogan (W. Parlett)
13. Birthplace: Balto. Md.

MOTHER
14. Maiden Name: Margaret M. Tyler
15. Birthplace: Crisfield Md.

16 (a) Informant: Mrs. Margaret M. (Grogan) Parlett
(b) Address: 3147 Frederick Ave. 29

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 21 1945 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: Balto. Md.

18 (a) Funeral director: Robert S. Little
(b) Address: 2700 Edmondson Ave.

19 (a) Dec 19 1945 (b) Deputy Registrar: Huntington Williams

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 17, 1945, at 12:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Intracerebral hemorrhage, spontaneous

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: Robert Lee Grayson M.D.
Medical Examiner.
Date signed December 17, 1945.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35285

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G35285

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1925 Hollins
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 yrs 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1925 Hollins St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William A Eckhardt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Widowed

6 (b) Name of husband or wife Margaret M

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 6 - 1868

8. AGE: Years	Months	Days	If less than one day
77	11	11	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business Bro Mfr

FATHER
12. Name Wm A Eckhardt
13. Birthplace Md

MOTHER
14. Maiden Name Not Known
15. Birthplace Md

16 (a) Informant Mrs Paul Bohn
(b) Address 1925 Hollins St

17 (a) Burial (b) Date thereof 12-20-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location Balto Md

18 (a) Funeral director George A Epley
(b) Address Fulton & Fayette

19 (a) DEC 19 1945 (b)
(Date rec'd by registrar) Registrar

Covington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 17 1945, at 11:05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1945 to Dec 17 1945 and that I last saw h[illegible] alive on Dec 15 1945.

Immediate cause of death	Duration
(a) Coronary Thrombosis	Sudden
Due to (b) Cardio Vascular Renal	1½ yrs
Due to (c) Multiple Embolic	2 wks
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Elliot W. Johnson M. D.
Address 3432 Wisteria Dr Date signed

X

G35286

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. G35286

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 107 N. Schroeder
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Green

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	married

6 (b) Name of husband or wife Adele Green

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1919-12-28

8. AGE: Years	Months	Days	If less than one day
25 26	11	19	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Robert Green
13. Birthplace Montgomery Co. Md.

MOTHER
14. Maiden Name Vida Johnsons.
15. Birthplace Baltimore, Md.

16 (a) Informant Viola Johnson
(b) Address 107 N. Schroeder St

17 (a) Burial (b) Date thereof Dec. 20 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location

18 (a) Funeral director Mrs Katie B. Williams
(b) Address 322 N Schroeder St

19 (a) DEC 19 1945 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 16 - 1945, at 11 A. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☑ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Epidural hematoma

Due to Skull fracture

Other Conditions Small superficial laceration of scalp.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-15-45 at P. M.
(b) Where did injury occur? Undetermined by Police
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no.
(d) Means of injury Unknown: Police unable to determine.

23. Signature Benedict Skotarelic M.D.
Medical Examiner.
Date signed 12-16-45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

G35287

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

124 B

Registered No. G35287

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 824 N Carrollton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 d
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 824 N Carrollton Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Alexander Hooper

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	C.	Married

6 (b) Name of husband or wife Mamie B Hooper
6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) ? 1891

8. AGE: Years	Months	Days	If less than one day
54			hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name George Hooper
13. Birthplace Md.

MOTHER
14. Maiden Name Mary P. —
15. Birthplace Md.

16 (a) Informant Mamie B Hooper
(b) Address 824 N Carrollton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 19, 45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 324 N Schroeder St
(Date rec'd by registrar) DEC 19 1945 (b) Huntingtor Williams Jr

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 19 1945, at 5' P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 9 1945, to Dec 19 1945, and that I last saw him alive on Dec 19 1945

Immediate cause of death Cerebral Thrombosis

Due to Cardio Vascular Disease

Due to Hypertension

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
6 mo's
6 mos
6 mo's

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E William Frey M. D.
Address 1928 Penna Ave Date signed 12/19/45

G35288

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

HB 94070

Registered No. G35288

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 8 18
(e) Length of stay in Baltimore (yrs., mos., or days) 45 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 815 Vine St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marie Elizabeth Mason

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	C	Married

6 (b) Name of husband or wife Elmer Mason
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 22, 1900

8. AGE: Years	Months	Days	If less than one day
45	2	15	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Lewis Myers (d)
13. Birthplace Md.

MOTHER
14. Maiden Name Laura Harvey
15. Birthplace Md.

16 (a) Informant Balto. City Hospitals (Records)
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 20, 1945 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cem.
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 3221 Lehmgrove St
(c) Name of licensed undertaker Williams Mortuary

DEC 19 1945
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 16, 1945, at 9:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 8, 1945 to Dec. 16, 1945, and that I last saw her alive on Dec. 16, 1945.

Immediate cause of death: Pulmonary Tuberculosis
Due to: Tuberculosis Enteritis
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)

Duration: ?

Date of operation:
Major findings of operation:
of autopsy: No Post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Herbert B. Copeland Jr. M. D.
Address Balt. City Hosp. Date signed 12/19/45

X

G35289

BALTIMORE CITY HEALTH DEPARTMENT

HB 96726

CERTIFICATE OF DEATH 13 B

Registered No. G35289

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 15 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 746 Bradley St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Moore

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Married

6 (b) Name of husband or wife William Moore
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 28, 1920

8. AGE: Years	Months	Days	If less than one day
25	11	10 20	hr. min.

9. Birthplace North Carolina
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Elijah Ward
13. Birthplace N.Carolina

MOTHER
14. Maiden Name Nancy Dove
15. Birthplace N.Carolina

16 (a) Informant Balto. City Hospitals (Records)
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 21, 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St
(Date received by local registrar) DEC 19 1945 Huntington Williams, Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 17, 1945 at 11:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 17, 1945, to Dec. 17, 1945, and that I last saw h. or alive on Dec. 17, 1945.

Immediate cause of death: Pulmonary Tuberculosis — Duration 2

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no Post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert B. Poland Jr. M.D.
Address Balt. City Hosp. Date signed 12/18/45

635290

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

635290
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Pikesville Reisterstown
(If outside city or town limits write RURAL and give town)
(d) Street No. 2 Central Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Corriveau

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Edith B.

6 (c) If alive, give age 27 years

7. Birth date of deceased (mo., day, yr.) Jan. 19, 1920

8. AGE: Years 26 | Months 10 | Days 28 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Laundry Driver

11. Industry or business

FATHER
12. Name Wm. Thomas Corriveau
13. Birthplace Harford County

MOTHER
14. Maiden Name Mary Edith Zinkham
15. Birthplace Jacksonville, Balto. Co., Md.

16 (a) Informant Wm. T. Corriveau
(b) Address Reisterstown, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 21, '45 (month) (day) (year)

(c) Cemetery or crematory All Saints
Location Reisterstown, Md.

18 (a) Funeral director Wm. Berryman & Sons
(b) Address Reisterstown, Md.

19 (a) Dec 19 1945 (Date received by registrar) (b) Thomas Worthington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 16 1945, at 2:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured Skull

Due to

Other Conditions Multiple wounds.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury December 16 1945 2:35 A.M.
(b) Where did injury occur? Butler Rd, Glyndon Balto. Co. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury Passenger Auto into telegraph pole

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 12-17-45

VS 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly. The

635291

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170c

635291

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hosp. 27 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5209 Belmore Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Campbell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife Bessie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 24, 1875

8. AGE: Years	Months	Days	If less than one day
70	1	20	hr. min.

9. Birthplace Pikesville Md (Town, county and state)

10. Usual Occupation Janitor

11. Industry or business

FATHER
12. Name George Campbell
13. Birthplace Maryland

MOTHER
14. Maiden Name Martha Toogood
15. Birthplace New Jersey

16 (a) Informant Bessie Campbell
(b) Address 5209 Belmore Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 17 1945 (month) (day) (year)
(c) Cemetery or crematory St. Thomas
Location Baltimore Co. Md.

18 (a) Funeral director Thos. H. Hall
(b) Address 1631 Druid Hill Ave

19 DEC 19 1945 (Date filed by registrar) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 14, 1945 at 10:40 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Skull fracture
Intracranial hemorrhage

Other Conditions Fracture of ribs, left
Fract. tibia and fibula left leg.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-12-45 3:35 P.M. 27/17
(b) Where did injury occur? In vicinity of 5227 Park Heights Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian struck by auto
Signature Benedict Peterelis M.D. Medical Examiner.
Date signed 12-15-45.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35292

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G35292 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun
(c) Hospital or institution: Franklin Square Hosp. 2032
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3d.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2638 Lauretta Ave. 23
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Boughan, Frederick {Frederick H. Boughan

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-01-1898

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Mrs Florence Boughan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 11-189[illegible]

8. AGE: Years	Months	Days	If less than one day
52	8-	4	- hr. - min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business
FATHER 12. Name John G Boughan
13. Birthplace Virginia
MOTHER 14. Maiden Name Georganna Taylor
15. Birthplace Virginia
16 (a) Informant Florence M Boughan
(b) Address 2638 Lauretta Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/19/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md
18 (a) Funeral director F. B. Wippert Son
(b) Address 852 W. Baltimore St
DEC 19 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-15- 1945, at 5:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12- 1935, to 12-15- 1945 and that I last saw him alive on 12-15- 1945

Immediate cause of death Acute Cardiac Failure — Duration 5 days

Due to Bilateral Bronchopneumonia

Due to

Other Conditions Patent Foramen Ovale — Duration Life.
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 54 S. Fulton Ave Date signed 12-16-45

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

635293

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92B

635293 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2428 Francis
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 3
(e) Length of stay in Baltimore (yrs., mos., or days) 60yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2428 Francis (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Winnie Marshall

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife James Marshall

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 12 1868

8. AGE: Years 77 | Months 11 | Days 5 | If less than one day hr. min.

9. Birthplace Westmoreland Co. Va (Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name Richard Stewart
13. Birthplace Westmoreland Co. Va.

MOTHER
14. Maiden Name Harriet Braxton
15. Birthplace Westmoreland Co. Va.

16 (a) Informant Nellie Harden
(b) Address 2428 Francis ST

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-21-45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location md

18 (a) Funeral director George H. Kelson
(b) Address 1303 Pennsylvania Ave

19 (a) (Signature of local registrar) (b) Registrar

DEC 19 1945
VS 150 Huntington Williams, M.D.

MEDICAL CERTIFICATION M.

20. DATE OF DEATH Dec 17 1945, at 4.10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 12 1945, to Dec 17 1945, and that I last saw h[illegible] alive on Dec 17 1945

	Duration
Immediate cause of death Chr. Valvular Heart	1940
Due to Disease (Mitral)	
Due to Arteriosclerosis	1940
Other Left Hemiplegia	1940

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(c) Means of injury

23. Signature Jane Brown

Address 1663 A North Date signed 12/17/45 M. D.

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35294

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1-136 B

G35294 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State NC (b) County
(c) City or town Henderson (If outside city or town limits, write RURAL and give town)
(d) Street No. 160 Church St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Katherine Perry
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Bennett
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 12-7-97
8. AGE: Years 47 Months - Days 11 If less than one day hr. min.
9. Birthplace NC (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name Robert B. Deane
13. Birthplace Md

MOTHER
14. Maiden Name Marie Skinner
15. Birthplace NC

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/21/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Elmwood
Location Henderson, N.C.
18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 220 Eutaw Place
DEC 19 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 18 1945 at 11 40 M
21. I certify that death occurred on the date above stated; that I attended deceased from Oct 26 1945 to Dec 18 1945 and that I last saw h. alive on Dec 18 1945.

	Duration
Immediate cause of death: Hyperpyrexia	69 days
Due to: ? urinary tract infection	
Due to:	
Other Conditions: Depressive reaction (Include pregnancy within 3 months of death)	

Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Laura S. Taylor M. D.
Address Johns Hopkins Hospital Date signed Dec. 18, 1945

G35295

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 178a

Registered No. G35295

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 3-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 112 N. Albemarle St. 3rd floor
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Malacky

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife Douglas
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1890

8. AGE: Years 55 | Months | Days | If less than one day hr. min.

9. Birthplace ? (Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business

FATHER
12. Name Joseph Pleard
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant ?
(b) Address ?

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 21 1945 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Fred W Ozarowski
(b) Address 1930 Eastern Ave.

DEC 19 1945
(a) Date received by registrar (b) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-17- 1945, at 10 55 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation

Due to Illuminating Gas

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-17- at 3/2 A.M.
(b) Where did injury occur? 112 N. Albemarle St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no
(d) Means of injury Unconnected gas hose & stove.

23. Signature Howard J. Rudolph M.D.
Medical Examiner.
Date signed 12-17-45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

635296

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 830

635296 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6325 Hudson
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6325 Hudson
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George W. Fifer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Mary C Fifer
6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) June 19 1874

8. AGE: Years	Months	Days	If less than one day
71	5	28	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Electrician
11. Industry or business Balto City

FATHER
12. Name Archibald Fifer
13. Birthplace Balto

MOTHER
14. Maiden Name Elizabeth Grant
15. Birthplace Balto

16 (a) Informant Mrs. Mary C Fifer
(b) Address 6325 Hudson

17 (a) Burial (b) Date thereof Dec 20 44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location City

18 (a) Funeral director Ellerich Funeral Home
(b) Address 2008 Orleans St

19 (a) (Date rec'd by local reg.) (b) Huntington Williamsport, Md.

Dec 19 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 17 1944, at 6:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 3 1944, to Dec. 17 1944; and that I last saw h[illegible] alive on Dec 17 1944.

Immediate cause of death

Cerebral Hemorrhage

Duration
2½ mos.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation No
Major findings of operation:

of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature James F White M.d. M. D.
Address 7601 Eastern Ave Balto. 24, Md. Date signed 12/19/44

X

G35297

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G35297

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N Caroline St
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 725 N. Chester St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Adeline Celeste

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widowed

6 (b) Name of husband or wife: Leo A Celeste
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 3 1871

8. AGE: Years	Months	Days	If less than one day
74	6	16	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business At Home

FATHER
12. Name Carl Staut
13. Birthplace Germany

MOTHER
14. Maiden Name Ottilia Helmina Gropp
15. Birthplace Germany

16 (a) Informant Leo A Celeste
(b) Address 2606 Halcyon Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 22 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2[illegible] Pennsylvania Ave

19 (a) DEC 19 1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/19 1945, at 8 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/29 1945 to 12/19 1945 and that I last saw her alive on 12/19 1945

Immediate cause of death: Cardiac Failure — Duration

Due to: Arteriosclerotic Cardio Vascular Disease

Due to

Other conditions: Diabetes Mellitus Gangrene Rt leg (Include pregnancy within 3 months of death)

Date of operation 12/18/45

Major findings of operation: Gangrene Rt leg

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work?
(e) Means of injury

23. Signature Irvin Jamonlie

Address St Joseph Hospt. Date signed 12/19/45

VS 150

Lockman

635298

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 473

635298 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2908 Elliott St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2908 Elliott St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary E. Frohman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Robert Frohman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 25 1881

8. AGE: Years 65 | Months 10 | Days 8 23 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Home, Wife

11. Industry or business

FATHER
12. Name Otto Lockman
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Wetzel
15. Birthplace Germany

16 (a) Informant Robert Frohman
(b) Address 564 S. East Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 20 1945 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Overlea Pike Road

18 (a) Funeral director Randall & Hupfel
(b) Address 312 S. Highland Ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams Registrar

DEC 19 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH December 17 1945, at 8 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from September 5 1945 to December 16 1945, and that I last saw her alive on December 16 1945

Immediate cause of death Carcinoma of the Lungs

Due to unknown

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

Duration: one year

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. A. Rosenblatt M. D.

Address 3018 O'Donnell St. Date signed 12-19-45

X

635299

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

178a

Registered No. 635299

write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address A
(c) Hospital or institution: West Baltimore General

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos
(e) Length of stay in Baltimore (yrs., mos., or days) DOA

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4700 Park Heights Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME NORA A. CALDWELL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Andrea P. Caldwell,

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 20, 1881

8. AGE: Years (64) 64 | Months 0 | Days 27 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Housewife,

11. Industry or business at home

FATHER
12. Name John W. Cummings,
13. Birthplace Ireland,

MOTHER
14. Maiden Name Johana Heaphy,
15. Birthplace Ireland,

16 (a) Informant Andrew V. Caldwell,
(b) Address 3509 Old Mill Road,

17 (a) Burial, (Burial, cremation, or removal) (b) Date thereof 12/20/45 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Baltimore City,

18 (a) Funeral director C. Vernon Lemmon
(b) Address 4611 Park Heights Ave.

DEC 19 1945 (Date received by registrar) (d) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/17/45 19..., at ... M

21. I certify that I took charge of the remains described above, held an Inspection Inquest on and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carbon Monoxide Poisoning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12/17 at 6 P. M.
(b) Where did injury occur? Home
(c) Did injury occur at home, on farm, industrial place, in public place? 4700 Park Heights Ave (Give street address or R.F.D. number or place at which injury occurred)
(d) Means of injury Gas

23. Signature John R Davis M.D.
Medical Examiner.
Date signed 12/18/45

(over)

635300

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

635300
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rukland & Raymond Ave
(c) Hospital or institution:
West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 35 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2543 Edmondson Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Edwin L. Tompkins

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Bessie C.
6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) April 16, 1898

8. AGE: Years	Months	Days	If less than one day
47	8	2	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Chief account Clerk
11. Industry or business City of Baltimore

FATHER
12. Name Lemuel Tompkins
13. Birthplace Pa.

MOTHER
14. Maiden Name Ella Bell
15. Birthplace W. Va.

16 (a) Informant Mrs. Bessie C. Tompkins
(b) Address 2543 Edmondson Ave.

17 (a) Burial (b) Date thereof 12/21/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Baltimore, Md.

18 (a) Funeral director William J. Tickner & Sons
(b) Address North & Pennsylvania Aves

19 (a) DEC 19 1945
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-18 1945, at 1:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-13 1945 to 12-18 1945 and that I last saw him alive on 12-18 1945

Immediate cause of death	Duration
Pulmonary Failure	
Due to Bronchogenic Carcinoma	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. A. Baldwin M. D.
Address West Baltimore General Hosp. Date signed 12-19-45

VS 150

G35301

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95 B

Registered No. G35301

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos
(e) Length of stay in Baltimore (yrs., mos., or days) 56 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3505 Windsor Mill Road
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Nannie Gertrud McCaffery

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	Wh.	Single

6 (b) Name of husband or wife X
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct - 8 - 1889

8. AGE: Years	Months	Days	If less than one day
56	2	10	hr. min.

9. Birthplace Maryland -
(Town, county, and state)
10. Usual Occupation Saleswoman
11. Industry or business

FATHER
12. Name Aloysius McCaffery
13. Birthplace Maryland

MOTHER
14. Maiden Name Anne V Hardin
15. Birthplace Maryland

16 (a) Informant D. N. Kirwan
(b) Address 3010 Winterbourne Road

17 (a) Burial (b) Date thereof 12/20/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral,
Location Old Frederick Rd.

18 (a) Funeral director Wm. J. Dickman & Sons
(b) Address North & Pa.

19 (a) (Date received by registrar) DEC 19 1945 (Registrar) Huntington Millwood, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec - 18 - 1945; at 1 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 18 1945 to Dec 18 1945, and that I last saw h[illegible] alive on Dec 18 1945.

Immediate cause of death	Duration
Cardiac Failure	
Due to Rheumatic Ht. Dis.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George H. Kirwan M. D.
Address Date signed 12/19/45

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35302

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. G35302

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3418 Toone St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3418 Toone ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Delma R. Scheller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Charles F.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 19, 1876

8. AGE: Years	Months	Days	If less than one day
69	6	27	hr. min.

9. Birthplace Frederick Co. Md.
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name George W. Harn
13. Birthplace Maryland

MOTHER
14. Maiden Name Catherine
15. Birthplace Maryland

16 (a) Informant Charles F. Scheller
(b) Address 3418 Toome St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/20/45 (month) (day) (year)
(c) Cemetery or crematory Taylorsville
Location Taylorsville Md.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 N. Broadway

19 (a) DEC 19 1945 (Date received by Registrar) (b) Hunter Stor Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 16 1945, at 9 45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 12 1945 to Dec 16 1945 and that I last saw h[illegible] alive on Dec 15 1945

Immediate cause of death	Duration
Intestinal Obstruction	12-13-45
Due to Carcinoma of Stomach	9-12-45
Due to	
Other Conditions None	

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence None at M
(c) Where did injury occur? None
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature E. A. Schumacher M. D.
Address 842 Cathedral Date signed 12-17-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35303

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 1628

Registered No. G35303

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 N. Cold Spring Lane
(c) Hospital or institution: Cold Spring Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Hyde
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katharine Linwood

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife. late Harry Linwood

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 15 - 1866

8. AGE: Years 79 | Months 4 | Days 1 | If less than one day hr. min.

9. Birthplace Unknown (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace X

MOTHER 14. Maiden Name Unknown

15. Birthplace X

16 (a) Informant Mrs. Hebert Weichert

(b) Address Hyde Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 19-45 (month) (day) (year)

(c) Cemetery or crematory Fork M. E. Cem

Location Fork Md.

18 (a) Funeral director Clarence E. Arthur

(b) Address Fork Md.

19 (a) DEC 19 1945 (Date received by Registrar) (b) Huntington Williamsville, Md. Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 17 1945, at 9:40 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 29 1945, to Dec. 17 1945, and that I last saw her alive on Dec 11 1945

Immediate cause of death Senility — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. N. Cutterman

Address 2324 Reisterstown Rd Date signed 12/18/45 M. D.

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

635304

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 635304

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., ~~or days~~) 5
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Co. Fork
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Earl S. Beaver

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, ~~married, widowed, or divorced~~
M	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 29 - 1929

8. AGE: Years	Months	Days	If less than one day
16	10	26	hr. min.

9. Birthplace York Pa. (Town, county, and state)
10. Usual Occupation Student
11. Industry or business

FATHER
12. Name Tilton S. Beaver
13. Birthplace Md.

MOTHER
14. Maiden Name Florence E. Spencer
15. Birthplace York Pa.

16 (a) Informant Hospital records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12.20-45 (month) (day) (year)
(c) Cemetery or crematory Fork Christian
Location Fork Md.

18 (a) Funeral director Clarence E. Arthur
(b) Address Fork Md.

19 (a) DEC 19 1945 (Date received by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-18 1945, at 2:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-13 1945 to 12-18 1945
and that I last saw h~~e~~ alive on 12-17 1945.

Immediate cause of death	Duration
Acute Leukemia & Influenza	
Due to Hypoproteinemia	
Due to Acute Leukemia Myeloblastoma Leukemia	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank M. Shipley M. D.
Address Church Home & Hospital Date signed 12-19-45

VS 150

G35305

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G35305

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2238 E North Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2238 E. North Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Myrtle R Caldwell

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife William

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb-18-1885

8. AGE: Years 60 | Months 9 | Days 28 | If less than one day hr. min.

9. Birthplace Harford Co. Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business At Home

FATHER
12. Name Isaac S. Partridge
13. Birthplace Bel Air Co. Md.

MOTHER
14. Maiden Name Melina Lowe
15. Birthplace Harford Co. Md

16 (a) Informant Brenda B Beatty
(b) Address 2238 E. North Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-20-45 (month) (day) (year)
(c) Cemetery or crematory Lakewood Mem
Location Taylor Ave

18 (a) Funeral director H. E. Malley Inc
(b) Address 2425 E. North Ave

19 (a) Date received by local registrar DEC 19 1945 (b) Thomas Livingston Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-16 1945 at 8:P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-45 19 to 12-16-45 19 and that I last saw h[illegible] alive on 12-16-45 19

Immediate cause of death Coronary Thrombosis — Duration 6 mo +

Due to Myocardial Infarction

Due to Rheumatic Nephritis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature E. Bayne
Address 642 Wash Blvd Date signed 12-18-45 M.

Randle X

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35306

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95 B

G35306
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Community Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4d.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore, Md Govans Pk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1243 Beechwood Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Sojak

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Joseph Sodjak
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 17, 1903

8. AGE: Years 42 | Months - | Days 29 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER 12. Name Joseph Maritz
13. Birthplace Czechoslovakia

MOTHER 14. Maiden Name Anna Lebalich
15. Birthplace Czechoslovakia

16 (a) Informant Jos. G. Sojak
(b) Address 1243 Beechwood Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-20-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balt Md

18 (a) Funeral director Frank Brachbon Son
(b) Address 9004 Chesterfield

19 (a) DEC 19 19 Registrar
(b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/16 1945, at 9 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/12 1945, to 12/16 1945, and that I last saw he alive on 12/16 1945.

Immediate cause of death Cardio - Resp. Failure

Duration

Due to Acute Rheumatic Heart Failure

Due to Endocarditis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. M. Lazy M. D.
Address Community Hosp Signed

G35307

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G35307 / 123

Registered No. G35307

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Be sure to state the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount Sts
(c) Hospital or institution: CHURCH HOME AND HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 days
(e) Length of stay in Baltimore (yrs., mos., or days) 60 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 432 W. Lafayette Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John C. Beiman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	married

6 (b) Name of husband or wife Anna A. Beiman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-15-84

8. AGE: Years	Months	Days	If less than one day
61 60	10	3	hr. min.

9. Birthplace Baltimore Md. (Town, County, and state)

10. Usual Occupation Guard

11. Industry or business

FATHER
12. Name Abraham H. Geniman
13. Birthplace Carroll County Md

MOTHER
14. Maiden Name Jane Fabulele
15. Birthplace Carroll County Md

16 (a) Informant wife
(b) Address 432 Lafayette Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-21-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto Md

18 (a) Funeral director Frank Brackston
(b) Address 900 E. Chester St

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

DEC 19 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH December 18 1945 at 2:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw him alive on Dec. 18 19 45

Immediate cause of death	Duration
Generalized peritonitis	5 days
Due to Perforating Ulcer Duodenum	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Multiple Diverticuli - Diverticulitis

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature O.W. Camponeschi M. D.

Address Church Home & Hospital Date signed 12/18/45

O.W. Camponeschi

635308

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1928

Registered No. 635308

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 920 E. Eager St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 920 E. Eager St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Theresa X. Freshline

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 9, 1925

8. AGE: Years	Months	Days	If less than one day
20	8 9	7	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Home Work
11. Industry or business at Home

FATHER
12. Name Henry M. Freshline
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Catherine E. Clinton
15. Birthplace Baltimore Md

16 (a) Informant Mr. Henry M. Freshline
(b) Address 920 E. Eager St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 20/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Rd

18 (a) Funeral director Elmer W. Confline & Son
(b) Address 924 E. Eager St.

19 (a) DEC 19 1945 (Date received by local registrar) (b) Huntington Willis, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-16-1945, at 5 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 7 1943 to 12/16 1945 and that I last saw her alive on 12/16 1945.

Immediate cause of death: Acute Cardiac Failure — Duration

Due to Ch. Myocarditis

Due to Mitral Stenosis

Other Conditions Acute Rheumatic Heart

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature A. L. Hornstein M. D.
Address 733 Ausquith St Date signed 12/17/45

VS 150

G35309 — BALTIMORE CITY HEALTH DEPARTMENT — G35309

CERTIFICATE OF DEATH 94a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 829 E. Chase St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 829 E. Chase St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Hugh J. Lavery

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Mary F. Lavery nee Straffe — 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 9, 1882

8. AGE: Years 63 | Months 10 | Days 9 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Chief in Baltimore
11. Industry or business City Fire Department

FATHER — 12. Name James J. Lavery
13. Birthplace Ireland

MOTHER — 14. Maiden Name Mary A. O'Hanlon
15. Birthplace Ireland

16 (a) Informant Miss Nellie Lavary
(b) Address 829 E. Chase St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 21/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location 4430 Belair Rd.

18 (a) Funeral director Elmer W. Confelder Son
(b) Address 924 E. Eager St.

19 (a) DEC 19 1945 (Date filed by registrar) Walter Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 17, 1945; at 11:47 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 9 1945 to Dec 17 1945 and that I last saw him alive on Dec 17 1945.

Immediate cause of death	Duration
Coronary Thrombosis	Dec 9/45
Due to Generalized Arteriosclerosis	Yrs. ?
Due to Hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William R. Straffe, M.D.
Address 10 E. Biddle St. Date signed Dec 19/45

VS 150

G35310

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1947

Registered No. G35310

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1912 Aliceanna Street
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore-31,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1912 Aliceanna Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Stanislaus Kedzierski OR STANLEY KING

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-09-6992

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov, 5th 1881

8. AGE: Years	Months	Days	If less than one day
64	1	13	hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation Ship Sealer

11. Industry or business

FATHER
12. Name Joseph Kedzierski
13. Birthplace Poland

MOTHER
14. Maiden Name Pelagia Wlodarek
15. Birthplace Poland

16 (a) Informant Veronica De Martin
(b) Address 1912 Aliceanna Street

17 (a) Burial (b) Date thereof 12-21-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory St. Stanislaus
Location Baltimore, Md.

18 (a) Funeral director George A Weber
(b) Address 705 S. Ann Street

DEC 19 1945 (b) Huntington Williams, Md.
(Date received by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec, 18th 1945, at 8 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 12 1945 to Dec. 18 1945 and that I last saw h— alive on Dec. 18 1945

Immediate cause of death	Duration
Acute Cardiac Dilatation	1 day.
Due to Carcinoma of Lung (Primary RL)	2 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John V. Kozierski M. D.
Address 1802 Eastern Ave Date signed 12-19-45

VS 150

G35311

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 106c

Registered No. G35311

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution: Maryland General 23
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7½ hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 19 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 23
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1700 Marshall St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dan Marshall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 28-1945

8. AGE: Years | Months | Days: 19 | If less than one day: hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John L. Marshall
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Evelyn A. Link
15. Birthplace Baltimore Md.

16 (a) Informant Mrs Evelyn A. Marshall
(b) Address 1700 Marshall St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-20-1945 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location A. A. Co. Md.

18 (a) Funeral director Flynn & Flannery
(b) Address 1916 Eutaw St

DEC 19 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/17 1945, at 9:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/17 1945, to 12/17 1945, and that I last saw him alive on 12/12 1945

Immediate cause of death	Duration
Acute Laryngo Tracheo Bronchitis, Pneumonia	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Martin E. Strobel M. D.
Address Md. Gen'l Hospital Date signed 12/18/45

635312

BALTIMORE CITY HEALTH DEPARTMENT X
CERTIFICATE OF DEATH √47?

635312
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
U.S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 days
(e) Length of stay in Baltimore (yrs., mos., or days) 19 days

2. USUAL RESIDENCE OF DECEASED:
(a) State RI (b) County
(c) City or town Lonsdale
(If outside city or town limits, write RURAL and give town)
(d) Street No. 44 Scott St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Lomax, Alfred Edward

3 (b) If veteran, name war

3 (c) Social Security Account No. 129-09-8293

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 10, 1901

8. AGE: Years	Months	Days	If less than one day
44	9	5	hr. min.

9. Birthplace Cumberland, RI
(Town, county, and state)
10. Usual Occupation AB seaman
11. Industry or business Seafarer

FATHER
12. Name John Lomax
13. Birthplace England

MOTHER
14. Maiden Name Margaret Taylor
15. Birthplace England

16 (a) Informant Records
(b) Address U.S. Marine Hospital

17 (a) BURIAL (b) Date thereof DEC. 20/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory ST. JOHNS
Location ELLICOTT CITY

18 (a) Funeral director Selby & Zeiler Inc.
(b) Address 403 S. WOLFE ST.

DEC 19 1945 Huntington Williams, M.D.
(Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 15 1945 at 8:55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 26 1945, to Dec. 15 1945, and that I last saw h. im alive on Dec. 15 1945

Immediate cause of death Hemorrhage, massive, terminal from gastric ulcer — Duration UNKNOWN

Due to Carcinoma right lung, upper lobe with widespread metastases — UNKNOWN

Due to Jaundice obstructive, due to metastatic tumor — UNKNOWN

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon
Address Clinical Director Date signed 12/17/45
US Marine Hospital, Balto, Md.

635313

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √50

Registered No. 635313

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto. Gen'l Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1029 Riverside Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country No

3 (a) **FULL NAME** Annie May Cook

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-31-90

8. AGE: Years 55 | Months 8 6 | Days 9 18 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Daniel Redell
13. Birthplace Penn.

MOTHER
14. Maiden Name Mary James
15. Birthplace Baltimore

16 (a) Informant Mrs. Margaret Schiers
(b) Address 1029 Riverside Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 22, 1945 (month) (day) (year)

(c) Cemetery or crematory New Cathedral
Location Edmondson Ave.

18 (a) Funeral director John F. Denny, Inc.
(b) Address 915 Light St.

19 (a) (Date received by Local Registrar) DEC 19 1945 (b) Signature of Local Registrar Jos. Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 18 1945, at 8:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 4 1945 to Dec 18 1945, and that I last saw her alive on Dec 18 1945.

Immediate cause of death	Duration
Acute Tracheo Bronchitis	
Due to	
Due to	
Other Conditions Arteriosclerosis of heart (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thos. E. Wheeler, M.D.
Address Balto Gen'l Hosp. Date signed 12/19/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35514

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

122a

G35514

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Mercy Hosp
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 days
(e) Length of stay in Baltimore (yrs., mos., or days) just came

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Marly Park, Glenburnie
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Theresa Joran (Joran)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Charles Joran

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 15, 1869

8. AGE: Years 74 | Months 4 | Days 3 | If less than one day hr. min.

9. Birthplace Bohemia (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Buma
13. Birthplace Bohemia

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Mrs. Frances Ellis
(b) Address Marley Park, Glenburnie, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/22/44 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Annapolis Blvd - AACo

18 (a) Funeral director John F. Deming Inc
(b) Address 714 Light St.

19 (a) (Date received by Registrar) (b) Washington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/18 1944, at 3:05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/21 1944, to 11/18 1944, and that I last saw her alive on 12/18 1944

Immediate cause of death Resp. Failure — Duration

Due to Peritonitis, generalized

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Strangulated femoral hernia - bowel perforated

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chas. Jackson M.D.

Address Mercy Hosp. Date signed 12/18/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35315 ✓ G35315

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6000 Bellona Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1654 Normal Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Annie A Brunn

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Herman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1, 1864

8. AGE: Years	Months	Days	If less than one day
81	7	18/7	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Michael Hammer
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Anne Sullivan
15. Birthplace Baltimore Md

16 (a) Informant Hammer Peter
(b) Address 1613 Milton St

17 (a) Burial (b) Date thereof 12/21/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director Wilson Funeral Home
(b) Address 1217 E Fayette St

19 (a) (b)
(Date rec'd by registrar) Registrar

DEC 20 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 19 1945 12:35 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 15 1945 to Dec 19 1945
and that I last saw he alive on Dec 19 1945

Immediate cause of death	Duration
(a) Chronic Myocarditis	Indy
Due to	
Due to	
Other conditions Arteriosclerosis	Indy
Chronic Nephritis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury

23. Signature D E Richards M.D.
Address 1710 N. Broadway St Date signed Dec. 1945

G35316

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

59 B

G35316 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1000 Caton Avenue
(c) Hospital or institution: Jenkins Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 37 days
(e) Length of stay in Baltimore (yrs., mos., or days) 37 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Pr. George's
(c) City or town Greenbelt (If outside city or town limits, write RURAL and give town)
(d) Street No. 5-B Ridge Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Alice V. Ruffin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife J. M. Ruffin
6 (c) If alive, give age 85 years

7. Birth date of deceased (mo., day, yr.) Nov. 4, 1872

8. AGE: Years	Months	Days	If less than one day
73	1	10	hr. min.

9. Birthplace Missouri (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Sam Yager
13. Birthplace Illinois

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Mary R. Hood
(b) Address 5-B Ridge Road, Greenbelt, Md.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 12/20/45 (month) (day) (year)
(c) Cemetery or crematory Riverdale
Location Prince George's Co. Md.

18 (a) Funeral director W. W. Chambers
(b) Address Riverdale Md.

19 (a) DEC 20 1945 (Date rec'd by registrar) (b) Hunter-Peter Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 19 1945 at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 12 1945 to Dec 19 1945 and that I last saw her alive on Dec. 19 1945

Immediate cause of death	Duration
(a) Hypostatic Pneumonia	
Due to (b) Generalized Arteriosclerosis & Myocardial failure	
Due to	
Other Conditions Mycosis Fungoides	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Hunter-Peter Williams, M.D.
Address Hyattsville Md. Date signed M./D. 12/19/45

G35317

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

G35317
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mrs. Bennett Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1916 Linden Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Eyrein Lewis

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Mulatto	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
about 45			hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation Bell Porter
11. Industry or business Furnish Porter Service

FATHER
12. Name Lewis
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Wilfred R. Allen
(b) Address 1518 Eutaw Place

17 (a) Burial (b) Date thereof 12/21/45
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Mt. Olivet
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 127 St. Paul st

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-10- 1945, at 12:20 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Pulmonary Edema
Hypertrophy & acute dilatation
Due to Heart

Other Conditions Chronic Nephritis
Generalized arteriosclerosis
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 12-10-45

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35318

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93a

Registered No. G35318

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 706 Harford Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 706 Harford Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carrie Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Lowis Brown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jany 18, 1900

8. AGE: Years 45 | Months 6 | Days 29 | If less than one day hr. min.

9. Birthplace Surrey County Va (Town, county, and State)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name John Mason
13. Birthplace Va

MOTHER
14. Maiden Name Florence Jones
15. Birthplace Va

16 (a) Informant Florence Brown = Daughter
(b) Address 706 Harford Ave

17 (a) Burial (b) Date of burial, cremation, or removal Dec 20 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Robert H. Grimm
(b) Address 704 N. Carey St

19 (a) (Date received by Registrar) DEC 20 1945 (b) Huntington Williams Registrar

VS-150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 16 1945, at 4:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-13-1945 to 12-16-1945 and that I last saw him alive on 12-16-1945

Immediate cause of death: Cerebral hemorrhage

Due to: Hypertension — Duration: 3 yrs. / 10 Days

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

If autopsy:

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

PHYSICIAN
Underline the cause to which death should be charged statistically.

29. Signature Wm. F. Leary M.D.
Address 1420 E. Clay Date signed 12-19-45

G35519

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 739

G35519
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp. 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) 34 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto. City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1600 North Pulaski St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Seherr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	wh.	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr - 12 - 1911

8. AGE: Years	Months	Days	If less than one day
34	8	7	hr. min.

9. Birthplace Baltimore - Md.
(Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business

FATHER
12. Name Harry Singer
13. Birthplace Russia

MOTHER
14. Maiden Name Sarah Seherr
15. Birthplace Russia

16 (a) Informant Mrs Sarah Singer
(b) Address 1600 North Pulaski

17 (a) Burial (b) Date thereof 12-21-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Pikesville Chapel
Location Wash Rd.

18 (a) Funeral director James L. Lamp Funeral Home
(b) Address 1439 E. Baltimore St

19 (a) (Date rec'd by registrar) (b) Registrar

DEC 20 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec - 19 - 1945, at 2 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec - 1 - 1945 to Dec - 19 - 1945, and that I last saw h.s.r alive on Dec - 19 - 1945.

Immediate cause of death: Aplastic Anemia — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Crawford M. Kirkpatrick, Jr. M.D.
Address Union Memorial Hosp Date signed 12-19-45

X

G35320 BALTIMORE CITY HEALTH DEPARTMENT G35320

CERTIFICATE OF DEATH

157 9

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town 5108 Walnut Ave
(If outside city or town limits, write RURAL and give town)
(d) Street No. University Hosp
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Cooper

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
	1	10	hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Robert N Cooper
13. Birthplace Maryland.

MOTHER 14. Maiden Name Helen E Engleman
15. Birthplace Maryland

16 (a) Informant Robert N Cooper
(b) Address 5108 Walnut Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year) Dec 20 45
(c) Cemetery or crematory Pleasant Hill
Location Balto Co.

18 (a) Funeral director E. J. McNabb
(b) Address Towsontown Md

19 (a) DEC 20 (b) 1945 (Date rec'd by registrar)
Hunter Williams, Jr. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/17 1945, at 7 45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/4 1945 to 12/17 1945, and that I last saw him alive on 12/17 1945.

Immediate cause of death: Surgical Shock — Duration

Due to repair of bilateral hare-lip.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 12/17/45

Major findings of operation: Bilateral hare-lip & cleft palate

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert Mark M. D.
Address Univ Hosp Date signed 12/17/45

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please correct age is especially important. Every item of information should be carefully supplied. The cause of death clearly and legibly.

G35321

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G35321 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 47yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3807 Helton Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clara Beresonsky

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Wht | 6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife Abraham

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1873

8. AGE: Years 72 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER 12. Name Morris

13. Birthplace Russia

MOTHER 14. Maiden Name Rachael

15. Birthplace Russia

16 (a) Informant Nathan Beresons

(b) Address 2419 Eutaw Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-20-45 (month) (day) (year)

(c) Cemetery or crematory Rosedale

Location Hamilton ave

18 (a) Funeral director Jack Lewis Son

(b) Address 1439 E Balto St

19 DEC 20 1945 (Date rec'd by registrar) Huntington Willia... (Signature of registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-19 1945 at 4:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-6 1945 to 12-19 1945 and that I last saw her alive on 12-19 1945

Immediate cause of death Rheumatic Heart Disease Mitral insuff + stenosis Aortic insuff + stenosis

Due to Cerebral decompensation

Due to Diabetic mellitus

Other Conditions Generalized arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: none

of autopsy: none

Duration
2½ Years
15 years

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Arnall Katz M. D.

Address Sinai Hosp Balt Md Date signed 12-17-45

G35322

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

G35322 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1402 E Balto St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3-
(e) Length of stay in Baltimore (yrs., mos., or days) 32yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1402 E. Balto St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Kavalsky

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Wht | 6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: Morris

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1891

8. AGE: Years 54 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Benjamin
13. Birthplace Russia

MOTHER
14. Maiden Name Bunne
15. Birthplace Russia

16 (a) Informant Bennie Kavalsky
(b) Address 1402 E. Balto St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-20-45 (month) (day) (year)
(c) Cemetery or crematory Hebrew Mt Carmel
Location Gorsuch Mill Road

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E Balto St

19 (a) (Date received by registrar) (b) Registrar

DEC 20 1945 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-19- 1945, at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct-10-1945, to Dec-19-1945 and that I last saw her alive on Dec-19-1945

Immediate cause of death: Carcinoma of Liver — Duration: about eight months

Due to

Due to

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Herman Seidel M. D.
Address 2404 Eastern Ave Date signed 12/29/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35323

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G35323 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1243 Sargeant St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1243 Sargeant St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah A. Galloway

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: George W. Galloway
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 12, 1863

8. AGE: Years 82 | Months 5 | Days 6 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER
12. Name Thomas Hawthorn
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary J. Moffitt
15. Birthplace Balto. Md

16 (a) Informant John P. S. Galloway
(b) Address 1236 Sargeant St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 22. 1945 (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet
Location City

18 (a) Funeral director Wm. H. Jno. H. Greufel & Son
(b) Address 601 W. Fayette St.

19 (a) DEC 20 1945 (Registrar's record received) Clayton Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 18 1945, at 7.25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 17 Dec 1945 to 18 Dec 1945 and that I last saw h.er alive on 18 Dec 1945.

	Duration
Immediate cause of death Bronchopneumonia (a) Primary	2 days
Due to	
Due to	
Other Conditions Chronic Myocarditis Myocardial degeneration	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work? —
(e) Means of injury —

23. Signature John P. Uelseka, Jr
Address 1227 Wash. Blv'd Date signed Dec 21 1945

VS 150

G35324

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 129

G35324 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution Maryland General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mo
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2917 Glenmore Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Henry A. Boehme BOEHME

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male

5. Color or race: W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Bertha P. Boehme

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 12 1881

8. AGE: Years 64 | Months 2 | Days 2 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Musician

11. Industry or business

FATHER
12. Name Frederick William Boehme
13. Birthplace Germany

MOTHER
14. Maiden Name Sandes Hemmerling
15. Birthplace Germany

16 (a) Informant Mrs Bertha P Boehme
(b) Address 2917 Glenmore Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-22-45 (month) (day) (year)
(c) Cemetery or crematory Lawson Park
Location Frederick Rd

18 (a) Funeral director Wendell L Humphreys
(b) Address 6067 Harford Rd

19 (d) DEC 20 1945 (Rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/19 1945 at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-9 1945, to 12-19-1945, and that I last saw him alive on 12-19 1945

Immediate cause of death: Respiratory Failure — Duration

Due to: Post Operative Pneumonia Following

Due to: Operation for Release of

Other Conditions: Adhesions Following Partial Obstruction

(Include pregnancy within 3 months of death)

Date of operation 12/11/45

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature G H Fuge Jr M. D.
Address Maryland Gen Hosp Date signed 12-19-45

G355325 84067

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 43B

Registrar's No. G355325

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1- 2- 2- days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 155 Enon Alley
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Fox

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? ?

8. AGE: Years	Months	Days	If less than one day
? 42	?	?	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) (Burial, cremation, or removal) (b) Date thereof Dec 21 1945 (month) (day) (year)

(c) Cemetery or crematory Mt Albion

Location

18 (a) Funeral director H. Halsted Dowd Hillcrest

(b) Address

19 (a) DEC 20 1945 (Date received by registrar) Registrar

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 19th. 1945 19 , at 9.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 29 19 45 to Dec. 19 19 45 and that I last saw him alive on Dec. 19 19 45

Immediate cause of death Cerebral Thrombosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: none

of autopsy: not requested

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature T. S. Jernigan M. D.

Address Baltimore City Hos Date signed 12-19-45

Hatcher

G35526

BALTIMORE CITY HEALTH DEPARTMENT ✓ G35326
CERTIFICATE OF DEATH 46B Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 215 W. Hoffman St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 215 W. Hoffman St. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gussie Cooper

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 6, 190

8. AGE: Years 44 | Months 10 | Days 11 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Edward Thorton
13. Birthplace Md.

MOTHER 14. Maiden Name Rosie
15. Birthplace Md.

16 (a) Informant Ellen D. Scott
(b) Address 130 W. Read St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-23-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave

19 (a) (Date rec'd by local reg.) (b) Burlington Williams M.D.

DEC 26 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 17, 1945, at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-17 1945 to 12/17 1945, and that I last saw h[illegible] alive on 12/17 1945.

Immediate cause of death: Carcinoma Stomach — Duration: 3 mo 0 da

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature B. J. Halahan M.D.
Address 1 W. Park Date signed 12/18/45

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G35327 ✓ G35327

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D-O-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3429 Elmora Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Hoos

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Estelle M. Hoos

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 4th 1882

8. AGE: Years 63. | Months 8 | Days 15 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Elevator Man

11. Industry or business B & O. R.R.

FATHER
12. Name Adam Hoos
13. Birthplace Md

MOTHER
14. Maiden Name Jane Earhart
15. Birthplace Penna

16 (a) Informant Mrs. E. Hoos
(b) Address 3429 Elmora Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 22nd 1945 (month) (day) (year)
(c) Cemetery or crematory Baltgrove
Location E. North Ave Ext

18 (a) Funeral director Leo B. Crooks
(b) Address 1701-03 N. Patterson Park Ave

19 (a) DEC 20 1945 (b) Registrar
Date received

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-19- 1945, at 7 20 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Weedon M.D. Medical Examiner.
Date signed 12-19-45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

Hunting for Will

G35328

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G35328

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4821 BOSTON ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 d
(e) Length of stay in Baltimore (yrs., mos., or days) 20 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4821 BOSTON ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: GEORGE TRUSHEIM JOECKEL

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. 217 09 4553

4. Sex: MALE

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: WIDOWER

6 (b) Name of husband or wife: ANNIE JOECKEL

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 5 1876

8. AGE: Years 69 | Months 5 | Days 13 | If less than one day hr. min.

9. Birthplace WASHINGTON DC.
(Town, county, and state)

10. Usual Occupation JUNK DEALER

11. Industry or business

FATHER
12. Name EDWARD TRUSHEIM
13. Birthplace DC.

MOTHER
14. Maiden Name CATHERINE JOECKELUPT
15. Birthplace DC.

16 (a) Informant ANNA ENGLEHAUPT (DAUGHTER)
(b) Address 4821 BOSTON ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof DEC. 21/45 (month) (day) (year)
(c) Cemetery or crematory WESTERN
Location EDMONDSON AVE.

18 (a) Funeral director Feilly & Geiler Inc.
(b) Address 403 S. WOLFE ST.

19 (a) DEC 20 1945 (Registered) Huntington Williams, M.D. Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH DEC. 18 1945, at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 10 1945 to Dec 18 1945 and that I last saw him alive on Dec 17 1945.

Immediate cause of death: Cerebral Hemorrhage — Duration 11 mos.
Due to: Hemiplegia — 11 mos.
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. B. Wolfe M. D.
Address 1279 Fulton Ave Date signed 12/19/45

X

FORM WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G355329

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

Registered No. G355329

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town) 2
(d) Street No. 306 Colvin Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SEFIO PITTMAN

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-05-1660

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Leola Pittman
6 (c) If alive, give age 35 years

7. Birth date of deceased (mo., day, yr.) July 1, 1893

8. AGE: Years	Months	Days	If less than one day
52	5	16	hr. min.

9. Birthplace Tarboro, N.C. (town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Harry Pittman
13. Birthplace N.C.

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Leola Pittman
(b) Address 306 N. Colvin St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-21-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location D.A.Co. Md.

18 (a) Funeral director Belmont Francis & Herring
(b) Address 72 Aisquith St

19 (a) (Date rec'd by registrar) (b)

DEC 20 1945

Hartin for W.H. Peters M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH December 17, 1945, at 11:15 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cardiac hypertrophy
& dilatation; Marked
pulmonary Emphysema
Due to

Other Conditions Acute alcoholism

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Bratton M.D. Medical Examiner.
Date signed Dec 19 1945

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G3533D

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G3533D
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 406 E. Cold Spring Lane
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 406 E. Cold Spring Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Doll Barnard

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife G. Oliver
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 22, 1873

8. AGE: Years	Months	Days	If less than one day
71	11	26	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John L. O'Neal
13. Birthplace Md.

MOTHER
14. Maiden Name Annie Hammondtree
15. Birthplace Md.

16 (a) Informant Mr. G. Oliver Barnard
(b) Address 406 E. Cold Spring Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/21/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director William J. Tickner & Sons
(b) Address North & Pennsylvania Aves

DEC 20 1945 Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 18, 1945; at 7:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 20 1945 to Dec 18 1945 and that I last saw h alive on Dec 18 1945.

Immediate cause of death	Duration
Cardio vascular disease	6 years.
Due to Arterio sclerosis	one year
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M D Bowman and Lord M. D.
Address 2200 Garrison Blvd Date signed 12-20-45

VS 150

635331 ✓ 635331

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1700 Park Ave.
(c) Hospital or institution: Wheeler Nursing Home 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4yrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1700 Park Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNIE G. HOCH

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Louis Hoch
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept. 29, 1863

8. AGE: Years	Months	Days	If less than one day
82	2	19	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Charles H. Gerhold
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Stetzer
15. Birthplace Germany

16 (a) Informant Miss Elsie E. Hoch
(b) Address 4230 Loch Raven Blvd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/20/45 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 DEC 20 1945 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 18, 1945, at 2:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1942, to Dec 18 1945 and that I last saw h es alive on Dec 17 1945.

Immediate cause of death	Duration
Cardio-vascular-hypertensive disease	6 yrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Roscoe C. Todd M. D.
Address 7108 St Paul St Date signed 12/19/45

VS 150

635332

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. 635332

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in especially important. Give the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2502 Queen Anne Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst., (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2502 Queen Anne Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BURTSON A. HICKCOX, SR.

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Ella G. Hickcox
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 25, 1873

8. AGE: Years	Months	Days	If less than one day
72	1	22	hr. min.

9. Birthplace Ohio
(Town, county, and state)
10. Usual Occupation Linotype Operator
11. Industry or business News-Post

FATHER
12. Name Joseph A. Hickcox
13. Birthplace

MOTHER
14. Maiden Name Margaret Brisky
15. Birthplace

16 (a) Informant Mrs. Ella G. Hickcox
(b) Address 2502 Queen Anne Rd.

17 (a) Entombment (Burial, cremation, or removal) (b) Date thereof 12/21/45 (month) (day) (year)
(c) Cemetery or crematory Mausoleum - Lorraine
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) DEC 20 1945 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 17, 1945, at 11:20 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 10 1940, to Dec 17 1945; and that I last saw deceased alive on Dec 17 1945.

	Duration
Immediate cause of death Cardiac Asthenia	5 days
Due to Arteriosclerosis	6 years
Due to Chronic Nephritis	9 years
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury —
23. Signature Herbert E. Zapp M. D.
Address 3048 N. North Ave. Baltimore 16 Md. Date signed

VS 150

G35333

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30 ✓

Registered No. G35333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Give the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3820 Chatham Road
(c) Hospital or institution:

15-10

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 8 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3820 Chatham Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose E. MacWilliams

3 (b) If veteran, name war: None

3 (c) Social Security Account No. None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Joseph S. MacWilliams

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 6, 1879

8. AGE: Years 66 | Months 0 | Days 13 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Henry Parr
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Louisa Ullrich
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Wm. M. Bowen
(b) Address 4004 Buckingham Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/2/45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director Wm. J. Tickner & Sons,
(b) Address North & Pa. Aves. Balto.

DEC 20 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 14 1945, at 7:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 11 1945, to Dec 14 1945, and that I last saw h.er alive on Dec. 11 1945.

	Duration
Immediate cause of death: Rupture of Aortic Aneurysm	1 day
Due to:	
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature O. S. Flynn M. D.
Address 1800 N. Charles Date signed 12-19-45

X

G35334 G35334

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts.
(c) Hospital or institution: Union Memorial Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 47 days
(e) Length of stay in Baltimore (yrs., mos., or days) 60 years

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2207 CHELSEA TERRACE
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Kathryn S. Moler (First) (Middle) (Last) (If unknown, state) Kathryn S. Moler

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: FEMALE
5. Color or race: White
6 (a) Single, married, widowed, or divorced: MARRIED
6 (b) Name of husband or wife: MR. THEODORE P. MOLER
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): Aug 4, 1885

8. AGE: Years	Months	Days	If less than one day
60	4	15	hr. min.

9. Birthplace: BALTIMORE, MD. (Town, county, and state)
10. Usual Occupation: HOUSE Wife
11. Industry or business

FATHER
12. Name: DANIEL S. JONES
13. Birthplace: BALTIMORE, MD.

MOTHER
14. Maiden Name: KATHERINE Roberts
15. Birthplace: BALTIMORE, MD

16 (a) Informant: Mr. Theodore P. Moler
(b) Address: 2207 Chelsea Terrace

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/22/45 (month) (day) (year)
(c) Cemetery or crematory: Mt. Olivet Cemetery
Location: Baltimore, Md.

18 (a) Funeral director: Wm. J. Tickner & Sons,
(b) Address: North & Pa. Aves. Balto. Md.

DEC 20 1945
(c) (Date received by Registrar) Huntington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: DECEMBER 19, 1945, at 11:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 2, 1945 to Dec 19, 1945, and that I last saw HER alive on Dec. 19, 1945.

Immediate cause of death: CARDIAC FAILURE — Duration

Due to: HYPERTENSIVE CARDIO-VASCULAR HEART DISEASE.

Due to: ARTERIO-SCLEROTIC CARDIO-VASCULAR DISEASE.

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: Crawford M. Kirkpatrick, Jr. M. D.
Address: Union Memorial Hosp. Date signed 12-19-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35335 97859

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 83 B

G35335 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 115 S. Arlington Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

18-3

3 (a) FULL NAME Herbert Morgan

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-12-7020

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Sadie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10th 1883

8. AGE: Years	Months	Days	If less than one day
62	6	9	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Noah Morgan
13. Birthplace Maryland

MOTHER
14. Maiden Name Susie Dison
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-22-45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto.

18 (a) Funeral director Frederick A. Cole
(b) Address 1200 W. Lombard St.

19 DEC 20 1945 (b) (Date received by registrar) Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 19th, 1945 at 11.30 A.M. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 13th 1945 to Dec. 19 1945 and that I last saw him alive on Dec. 19th 1945

Immediate cause of death Cerebral Thrombosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: none

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature T. P. Gerneger
Address Baltimore City Hosp Date signed 12-19-45 M. D.

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

635336

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

635336 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1620 N. Lexington
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1620 N. Lexington St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Patience F. Cooper

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex Female 5 Color or race Colored 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 22, 1865

8. AGE: Years 80 Months 5 Days 18 If less than one day hr. min.

9. Birthplace Hindsgr, N.C. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Hallen Cooper
13. Birthplace N.C.

MOTHER 14. Maiden Name Anna C. Barns
15. Birthplace N.C.

16 (a) Informant George W. Sattler
(b) Address 1609 Druid Hill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 22 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Mrs. Lew. H. Hoffman
(b) Address 1631 Druid Hill Ave

19 (a) DEC 20 1945 Registrar

Huntington Hollins M

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-15-45 19 10:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1943 19 12/13/45 and that I last saw h-- alive on 12/13/45

Immediate cause of death: Acute Pneumonia — Duration

Due to Epidemic

Due to " " Hemiplegia

Other Conditions Broncho-pneumonia

Date of operation

Major findings of operation: —

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. L. Barkdoll M. D.
Address 746 N. Eutaw Date signed 12/14/45

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35337

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G35337 Registered No. 3698

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1723 Lafayette Ave
(c) Hospital or institution: none 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) none
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1723 W. Lafayette Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Pernell Cole

3 (b) If veteran, name war: none
3 (c) Social Security Account No. 219-16-4118

4. Sex: male | 5. Color or race: colored | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Olivia Cole

6 (c) If alive, give age: | years

7. Birth date of deceased (mo., day, yr.) Nov 4 1924

8. AGE: Years: 21 | Months: 1 | Days: 15 | If less than one day: hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Shoe Repairer

11. Industry or business Aberdeen Md

FATHER 12. Name Leonard B. Cole

FATHER 13. Birthplace Lawson Md

MOTHER 14. Maiden Name Medorah Sharps

MOTHER 15. Birthplace Amerindale Co Md

16 (a) Informant Leonard B. Cole

16 (b) Address 1723 Lafayette Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/25/45 (month) (day) (year)

17 (c) Cemetery or crematory Mt Auburn

Location Md

18 (a) Funeral director Geo. V. Kelson

18 (b) Address 1303 Pennsylvan Ave

19 DEC 20 1945 Registrar's record received by registrar Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 — 19 1945, at 4:25 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-1 1945 to 12-19 1945, and that I last saw him alive on 12-18 1945.

Immediate cause of death	Duration
Pulmonary Tuberculosis	14 mo
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank A. Saunders M. D.
Address 29 N. Strycker Date signed 12-19-45

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35538

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G35538

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 113 S. Collington Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 113 S. Collington Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maryanna Borowiak

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Robert Borowiak

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unk.

8. AGE: Years 73 | Months | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation House Work

11. Industry or business at home

FATHER
12. Name Bentkowski
13. Birthplace Poland

MOTHER
14. Maiden Name Unk.
15. Birthplace Poland

16 (a) Informant William Borowiak
(b) Address 113 S. Collington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 21/45 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Fred W Ozarowski
(b) Address 1930 Eastern Ave.

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 18 1945, at 9 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 2 1945 to Dec 18 1945, and that I last saw h[illegible] alive on Dec 17 1945.

Immediate cause of death	Duration
Arteriosclerotic C. V. Disease	
Due to Cerebral Hemorrhage.	Jan 4/41
Due to Major cerebral Embolism	12-2/45
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None.
Major findings of operation: None.
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Eastchemand M. D.
Address 842 Eastern Date signed 12-19-45

VS 150
DEC 20 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

635539

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

635539

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 18 N Lakewood Ave.
(c) Hospital or institution: 6-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 18 N. Lakewood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: Thomas L. Wesolowski (Wessel)

3 (b) If veteran, name war:

3 (c) Social Security Account No. 216076457

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Frances

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 26 1886

8. AGE: Years 58 | Months 11 | Days 23 | If less than one day hr. min.

9. Birthplace: Poland (Town, county, and state)

10. Usual Occupation: Clerk

11. Industry or business

FATHER
12. Name: Thomas
13. Birthplace: Poland

MOTHER
14. Maiden Name: Unk.
15. Birthplace: Poland

16 (a) Informant: Frances Wesolowski
(b) Address: 18 N. Lakewood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Dec. 21/45 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Baltimore

18 (a) Funeral director: Fred W. Ozarowski
(b) Address: 1930 Eastern Ave.

19 (a) (b) Registered by registrar

DEC 20 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 13 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 9 1945, to Dec 13 1945, and that I last saw h[illegible] alive on Dec. 13 1945.

Immediate cause of death	Duration
Coronary Heart Disease	3 days
Due to Chronic Myocarditis	6 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: John V. Kozakiewicz M. D.
Address 1902 Eastern Ave Date signed 12-1945

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35540

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

52 B

G35540 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
U.S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 days
(e) Length of stay in Baltimore (yrs., mos., or days) 19 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Del. (b) County
(c) City or town Bowers
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Haldeman, Jay William

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	Married

6 (b) Name of husband or wife Virginia Haldeman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4, 1888

8. AGE: Years	Months	Days	If less than one day
57	5	15	hr. min.

9. Birthplace Phila, Pa. (Town, county, and state)
10. Usual Occupation firefighter
11. Industry or business

FATHER
12. Name Benjamin Haldeman
13. Birthplace Pa.

MOTHER
14. Maiden Name Mary Halterman
15. Birthplace Pa.

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Milford
Location Milford Del.
18 (a) Funeral director Wm a. Berry Jr.
(b) Address Milford, Del.
19 (a) DEC 20 1945 [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 19 1945 at 10:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 30 1945 to Dec. 19 1945 and that I last saw him alive on Dec. 19 1945.

Immediate cause of death Carcinoma of bladder, squamous cell type with ureteral obstruction — Duration 2½ yrs
Due to and uremia — 6 mos
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon
Address Clinical Director, US Marine Hospital, Balto, Md. Date signed 12/20/45 M.D.

VS 150

G35341

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

Registered No. G35341

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette & John St
(c) Hospital or institution: Hospital for the Women of Maryland 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 503 W. Franklin St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Everheart

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: none

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Thomas Everheart
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4 / 10 / 1858

8. AGE: Years 87 | Months 8 | Days 9 | If less than one day hr. min.

9. Birthplace Louttsville, Va. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name John Ritchie
13. Birthplace Maryland

MOTHER
14. Maiden Name Ann Ritchie
15. Birthplace Maryland

16 (a) Informant Mrs Wynona Sylvester
(b) Address 295 E Edmondson Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/27/45 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore Md

18 (a) Funeral director Mullaney Co
(b) Address 317 E Pratt St

DEC 20 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 / 19 1945, at 3:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11 / 29 1945 to 12 / 19 1945 and that I last saw her alive on 12 / 19 1945

Immediate cause of death: Carcinoma of Cervix — Duration: ? 6 mos.
Due to: Extension throughout pelvis
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Richard Compton M. D.
Address Hospital for Women Date signed 12-19-45

X

G35342

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. G35342

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 min
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N. Jersey (b) County
(c) City or town Perth Amboy (If outside city or town limits, write RURAL and give town)
(d) Street No. 96 Madison ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Philip Belikove

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years	Months	Days	If less than one day
49			hr. min.

9. Birthplace Perth Amboy N. J. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Samuel Belikove
13. Birthplace Russia

MOTHER
14. Maiden Name Dora Weinblatt
15. Birthplace Russia

16 (a) Informant Philip Costello
(b) Address Perth Amboy, N. J.

17 (a) Removal (b) Date thereof 12-20-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Progressive
Location Perth Amboy, N. J.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St Paul St

19 (a) DEC 20 1945 (b) Thanksgiving Wilson Director
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 17th 1945, at 10 18 P.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to Arteriosclerosis

Other Conditions Also old myocardial infarct.
(Including pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Deturelle M.D.
Medical Examiner.
Date signed 12-19-45

PRINT WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

635343

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52a

Registered No. 635343

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd and Calvert St.
(c) Hospital or institution: Union Memorial Hospital 15-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos 22 d.
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2647 Oswego Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mrs. Aaron Jacobs (Sadie)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	married

6 (b) Name of husband or wife Aaron Jacobs
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 12, 1909

8. AGE: Years	Months	Days	If less than one day
36	9	8	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Jacob Smith
13. Birthplace Russia

MOTHER
14. Maiden Name Bessie Doraine
15. Birthplace Russia

16 (a) Informant Mr Aaron Jacobs
(b) Address 2647 Oswego ave

17 (a) Burial (b) Date thereof Dec 23/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Shaarie Zion Cemetery
Location Hamilton ave & Rosedale

18 (a) Funeral director Sol Levinson & Bros.
(b) Address 1124-26 W. North ave
(Day) (Month) (Year) Registrar

DEC 20 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 19 1945 at 6:35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-27 1945 to 12-19 1945 and that I last saw h[illegible] alive on Dec 19 1945.

Immediate cause of death	Duration
Intestinal obst.	
Due to Hypernephroma	
Due to generalized metastasis	
Other Conditions Obst. of ureter	

(Include pregnancy within 3 months of death)
Date of operation Oct. 17, 1945, Exp. Lap.
Major findings of operation: Hypernephroma of Rt. kidney
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Crawford M. Kirkpatrick, Jr. M. D.
Address Union Memorial Hosp Date signed 12-19-45

VS 150

G35344

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. G35344

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correctly supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 574 St. Mary Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 574 St. Mary Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ROBERTA BROWN

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 1882

8. AGE: Years	Months	Days	If less than one day
63	1		hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Edmondson Page
13. Birthplace Va.

MOTHER
14. Maiden Name Rachel Blackston
15. Birthplace Va.

16 (a) Informant Mrs. Helen Woodson
(b) Address 574 St. Mary Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-22-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

DEC 20 1945 (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

P

20. DATE OF DEATH Dec. 18, 1945 at 5:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 4 1945 to Dec 18 1945 and that I last saw her alive on Dec 18 1945.

Immediate cause of death Carcinoma of Breast — Duration

Due to Mastitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Doug Lan Sheppard M. D.
Address 1631 W Franklin St Date signed 12/20/45

X

635345

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓181

Registered No. 635345

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Provident Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-A
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1409 Penna. ave.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Laura Henson

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	Single

6 (b) Name of husband or wife.....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1868

8. AGE: Years	Months	Days	If less than one day
77			.....hr. .....min.

9. Birthplace Baltimore - Md
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Peter Henson
13. Birthplace Va.

MOTHER
14. Maiden Name Lauretta White
15. Birthplace Va

16 (a) Informant Mrs. Lorraine Minter
(b) Address 427 Mosher St.

17 (a) Burial (b) Date thereof 12-21-43
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Laurel Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Lorraine A. Hensley
(b) Address 578 W. Biddle St.

19 (a) [illegible] (b) Pennington / Baltimore, Md.
(Date received by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-16- 1943; at 6 45 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Shock

Due to 2nd - 3rd degree burns

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12 48 - at ..... P. M.
(b) Where did injury occur? 1409 Penna. Ave. 114
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Clothes ignites while making a fire

23. Signature Thomas J. Mullen M.D.
Medical Examiner.
Date signed 12-19-43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

KONDRAT

C35346

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 479

Registered No. C35346

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1510 Cypress
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1510 Cypress St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Stanislaw Steve Kondrat

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W.

6 (a) Single, married, widowed, or divorced. M.

6 (b) Name of husband or wife Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 15 - 1878

8. AGE: Years 67 | Months 4 | Days 4 | If less than one day hr. min.

9. Birthplace Ukraine
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business City of Balto

FATHER
12. Name William
13. Birthplace Ukraine

MOTHER
14. Maiden Name Mary Kosowicz
15. Birthplace Ukraine

16 (a) Informant Mary Kondrat
(b) Address 1510 Cypress

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 21 - 45 (month) (day) (year)
(c) Cemetery or crematory Holy Cross Cem
Location A. A. Co.

18 (a) Funeral director Wm. S. Fialkowski
(b) Address 2007 Eastern ave

19 (a) DEC 20 1945 (Date rec'd by Reg.) (b) Interpreter Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 19 1945, at 7.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 15 1945, to Dec-19 1945, and that I last saw h/m alive on Dec. 18 1945

Immediate cause of death
Primary Carcinoma of Left Lung

Duration
?

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul Lubin M.D.

Address 320 Patapsco Ave. Date signed 12/20/45 M. D.

X

G35347

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 44a

G35347 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dec a
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 511 Register Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Hoffa

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Virgie M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 29 1900

8. AGE: Years	Months	Days	If less than one day
45	7	19	hr. min.

9. Birthplace Garrett Pa
(Town, county, and state)

10. Usual Occupation
11. Industry or business Lawyer

FATHER
12. Name Charles W Hoffa
13. Birthplace Tremont Pa

MOTHER
14. Maiden Name Margaret Young
15. Birthplace Scotland

16 (a) Informant Virgie M. Hoffa
(b) Address 511 Register Ave

17 (a) Burial (b) Date thereof Dec 22-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Western Mile Rd.

18 (a) Funeral director John A Wilson
(b) Address 3602 E. Baltimore St.

19 DEC 20 1945 Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 18 1945, at 2 30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to His death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Gratacap M.D.
Medical Examiner.
Date signed 12-18-45

G35348

485060

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157E

G35348 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6305 Mayflower Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Patricia Cornell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-14-40

8. AGE: Years	Months	Days	If less than one day
5	1	4	hr. min.

9. Birthplace md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Cornell
13. Birthplace md.

MOTHER
14. Maiden Name Rose Blair
15. Birthplace md.

16 (a) Informant Rhonda.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 31-45 (month) (day) (year)
(c) Cemetery or crematory Holy Rood.
Location Belair Road.

18 (a) Funeral director John A. McGan
(b) Address 300 E. Madison St

19 (a) DEC 29 1945 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH Dec. 18 1945, at 2.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 12 1945, to Dec. 18 1945 and that I last saw h[illegible] alive on Dec. 18 1945.

Immediate cause of death	Duration
Cardiac decompensation	
Due to Congenital Heart Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Blair Everett Batson M.D.
Assistant Resident
Address Johns Hopkins Hospital Date signed 12/28/45

X

G35349

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G35349

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 9 N. Calvert St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) Country
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town.)
(d) Street No. 10 W. Chase St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marie Hausler

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Sebastian

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 18-1890

8. AGE: Years 55 | Months 1 | Days - | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Michael Berger
13. Birthplace Germany

MOTHER
14. Maiden Name Brantdamm
15. Birthplace Germany

16 (a) Informant Sebastian Hausler
(b) Address 9 N. Calvert St

17 (a) Burial (b) Date thereof Dec 21-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave.

18 (a) Funeral director H. A. Ingram
(b) Address 300 E. Baltimore St

19 (a) DEC 20 1945 Registrar
(Date received by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 18 1945; at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1937 to Dec 18 1945 and that I last saw him alive on Dec 18 1945

Immediate cause of death Myocardial degeneration — Duration

Due to Hypertensive heart disease

Due to Hypertension, essential

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John J Hand M. D.
Address 142 E. Eager Ave Date signed 12-19-45

VS 150

635350

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. 635350

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2316 W.Lanvale St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16-5
(e) Length of stay in Baltimore (yrs., mos., or days) 1½ Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ***
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2316 W.Lanvale St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Ivan S.Burrows

3 (b) If veteran, name war: ---

3 (c) Social Security Account No. 717-07-5231

4. Sex: Male

5. Color or race: Wht.

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Rosa P.Burrows

6 (c) If alive, give age: 55 years

7. Birth date of deceased (mo., day, yr.) Dec. 5,1894

8. AGE: Years 51 | Months -- | Days 15 | If less than one day ... hr. ... min.

9. Birthplace Detroit Mich
(Town, county, and state)

10. Usual Occupation Supervisor of Accounting

11. Industry or business Penna. R.R.

FATHER
12. Name Absolem Burrows
13. Birthplace England

MOTHER
14. Maiden Name Unknown
15. Birthplace England

16 (a) Informant Mrs. Rosa P.Burrows
(b) Address 2316 W.Lanvale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 21, 1945 (month) (day) (year)
(c) Cemetery or crematory Evangelical Lutheran
Location Ardmore Pa.

18 (a) Funeral director Robert S.Little
(b) Address 2700 Edmondson Ave.

19 DEC 20 1945 (Date filed by Registrar) by Thurlington for Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 20, 1945 19... at 6 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 15 1945, to Dec. 20 1945 and that I last saw him alive on Dec. 20 1945

Immediate cause of death: Cerebral Hemorrhage — Duration 7 mos. (a)
Due to: Hypertension (b)
Due to: Arteriosclerosis. (c)
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel E. Bozard, M. D.
Address 1905 W. Baltimore Date signed 12/20/45

635351

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83 B

635351 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Providence Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dk.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits write RFD and give town)
(d) Street No. 547 Auburn St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Pembleton

3 (b) If veteran, name war: None
3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Separted

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-4-1895

8. AGE: Years 50 | Months 2 | Days 11 12 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation
11. Industry or business Janitor

FATHER
12. Name John W. Pembleton
13. Birthplace Maryland.

MOTHER
14. Maiden Name Helen Wilson
15. Birthplace Maryland

16 (a) Informant Mrs. Helen J. Johnson
(b) Address 638 N. Bruce Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-21-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Maryland

18 (a) Funeral director William A. Jackson
(b) Address 916 Penna, Ave.

19 (a) DEC 20 1945 (Date rec'd by registrar) [illegible] (Signature)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/16 1945, at 8:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☑ cause of death, fill in the following:
(a) Date of injury 12/14/45 at about 7:30 P.M. 11/4
(b) Where did injury occur? 1240 McCullough St
(c) Did injury occur at home, on farm, industrial place, in public place? above address While at work? No
(d) Means of injury Fell down steps

23. Signature [illegible] M.D. Medical Examiner.
Date signed 12/15/45

0 X

G35352

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G35352

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 412. N. Pearl Street
(c) Hospital or institution: 17
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 6 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 412 N. Pearl Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SARAH SHELL MOORE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 5 1910

8. AGE: Years 35 | Months 4 3 | Days 13 | If less than one day hr. min.

9. Birthplace Wilmington, N. C.,
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name L. W. Shell
13. Birthplace Columbia, S,C,

MOTHER
14. Maiden Name Sarah Coleman
15. Birthplace South Carolinia

16 (a) Informant Jesse Bell Burnes
(b) Address 412 N. Pearl Street

17 (a) Removal (b) Date thereof 12-21-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Wilmington, N.C.
Location Wilmington, N, C,

18 (a) Funeral director William A. Jackson
(b) Address 915 Penna, Ave.

19 (a) DEC 20 1945 (b) [illegible] Registrar
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH December, 19 19 45, at 9 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 17 1945 to Dec 19 1945, and that I last saw h[illegible] alive on Dec 18 1945.

Immediate cause of death Acute Lobar Pneumonia — Duration 3 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. B. Stewart M. D.
Address 632 Franklin St Date signed Dec 20

VS 150

G35353

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1159

Registered No. G35353

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green Sts
(c) Hospital or institution: University Hospital 4-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore, Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 718 W. Lexington St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Howard

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C.	Child

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/11/45

8. AGE: Years	Months	Days	If less than one day
		2.	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Dolores Howard
15. Birthplace Md.

16 (a) Informant Dolores Howard.
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School DEC 20 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 DEC 20 1945 (b) Registrar
(Date rec'd by registrar)

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-13 1945 at 9:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-11 1945 to 12-13 1945 and that I last saw her alive on 12-13 1945

Immediate cause of death Prematurity

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Mabel S. Drake M. D.

Address Univ. Hosp. Date signed 12-13-45

154

G35354

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 10

Registered No. G35354

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Leydenhaus Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 da
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 902 Whitelock (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: William Marquette Gilda

3 (b) If veteran, name war: World War II

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Wh

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mrs. Wm. M. Gilda

6 (c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) March 3, 1898

8. AGE: Years 47 | Months 9 | Days 16 | If less than one day ____ hr. ____ min.

9. Birthplace: Taneytown, Md. (Town, county, and state)

10. Usual Occupation: Insurance Agent

11. Industry or business

FATHER
12. Name: not known
13. Birthplace

MOTHER
14. Maiden Name: not known
15. Birthplace

16 (a) Informant: Step daughter
(b) Address: 902 Whitelock St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. '23 (month) (day) (year)
(c) Cemetery or crematory: Lutheran Evan Taneytown
Location: Taneytown Md.

18 (a) Funeral director: John A. Miller
(b) Address: 234 Jefferson St.

19 DEC 20 1945 [illegible] for Williams M.D. Registrar
(Date filed by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 19 1945, at 3:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 18 1945 to Dec 19 1945 and that I last saw him alive on Dec 19 1945.

Immediate cause of death: Laryngeal Edema — Duration: 2 days

Due to: Diphtheria — 3 days

Due to:

Other Conditions: Hypertension

(Include pregnancy within 3 months of death)

Date of operation: Dec 19, 1945

Major findings of operation: Tracheotomy

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature: Melchizedek Spraggs M.D.
Address: Leydenhaus Hosp Date signed 12-19-45

VS 150

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

635355

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Register's No. 635355

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto. Genl. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 D A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Washington
(c) City or town Baltimore Hagerstown
(If outside city or town limits, write RURAL and give town)
(d) Street No. 110 S. Cannon Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Antonio Cianelli

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: [illegible]

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 20/1886

8. AGE: Years 59 | Months 9 | Days 29 | If less than one day hr. min.

9. Birthplace Italy
(town, county, and state)

10. Usual Occupation Engineer

11. Industry or business Crane operator

FATHER
12. Name No Record
13. Birthplace " "

MOTHER
14. Maiden Name No Record
15. Birthplace No Record

16 (a) Informant David J. Cianelli
(b) Address Hagerstown Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/22/45 (month) (day) (year)
(c) Cemetery or crematory Rose Hill Cem
Location Hagerstown Md

18 (a) Funeral director A-K. Hoffman
(b) Address Hagerstown Md.

DEC 20 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 18 1945, at 4:20 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Life death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary occlusion
Cardiac Aneurysm
Due to

Other Conditions Arteriosclerosis, marked.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skotarelu M.D.
Medical Examiner.
Date signed 12-19-45

35356

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 E

Registered No. G35356

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St
(c) Hospital or institution: Bon Secours Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 609 N. Augusta Ave. Balto. Md. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mr. William Francis Lee

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M. | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 19 1878

8. AGE: Years 67 | Months 7 | Days 0 | If less than one day hr. min.

9. Birthplace Vermont (Town, county, and state)

10. Usual Occupation Caretaker

11. Industry or business City Parks

FATHER 12. Name James Lee
13. Birthplace Vermont

MOTHER 14. Maiden Name Mary Lawder
15. Birthplace Vermont

16 (a) Informant Wm F Lee
(b) Address 609 N Augusta Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-22-45 (month) (day) (year)
(c) Cemetery or crematory Catholic
Location Baltimore Md

18 (a) Funeral director Geo. A. Farley
(b) Address Fulton & Fayette

19 (a) DEC 20 1945 (Date rec'd by registrar) (b) Filed Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-19 1945, at 4:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-14 1945 to 12-19 1945 and that I last saw h alive on 12-19 1945

Immediate cause of death Carcinoma of Sigmoid — Duration 6 mos?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 12-15-45

Major findings of operation: Ca of Sigmoid Colon

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Richard C. Hayden M. D.
Address Bon Secours Date signed 12-19-45

VS 150

G35357

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G35357

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1513 N. Fayette St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1513 N. Fayette St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John L. Cullison

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Helen F.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 23, 1881

8. AGE: Years	Months	Days	If less than one day
63	5	25	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Painter Owner
11. Industry or business

FATHER
12. Name Happy Cullison
13. Birthplace Md.

MOTHER
14. Maiden Name Barbara Eichorn
15. Birthplace Md.

16 (a) Informant Helen F. Cullison
(b) Address 1513 N. Fayette St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 21, 1945 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto. Md.

18 (a) Funeral director E. A. Farley
(b) Address Baltimore and Fayette St.

19 (a) DEC 20 1945 (Date rec'd by registrar) (b) Huntington Hills Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/18 1945 at 8:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/15 1945 to 12/18 1945 and that I last saw h. alive on 12/17 1945

Immediate cause of death	Duration
Coronary Thrombosis	2 hrs
Due to	
Due to	
Other Conditions Duodenal Ulcer 3 days Stomach ache	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward Cullison M. D.
Address 2145 N. Balto St. Date signed

VS 150

94a

5358

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

160a

Registered No. 35358

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 32nd & Calvert St.
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 2

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balt.
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3408 St. Ambrose Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Sh:ffelt

3 (b) If veteran, name war 0
3 (c) Social Security Account No. 0

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/18/45

8. AGE: Years 0 | Months 0 | Days 2 1 | If less than one day 22 hr. 44 min.

9. Birthplace Union Mem. Hosp. Balt. (Town, county, and state)

10. Usual Occupation None.

11. Industry or business None.

FATHER
12. Name Pfc. Ernest L. Shiffelt.
13. Birthplace Balt. Md.

MOTHER
14. Maiden Name Ethel Ada Bryant. White
15. Birthplace Balt. Md.

16 (a) Informant Mrs. E.L. Shiffelt.
(b) Address 3408 St. Ambrose Av.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 21, 1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Md.

18 (a) Funeral director E. Willis Lamoreau
(b) Address 4510 Liberty Heights Ave.

1945 DEC 20 (b) Registrar

(c) Filed by Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 20 1945; at 10.45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/18 1945 to 12/20 1945, and that I last saw him alive on 12/20 1945.

Immediate cause of death Asphyxia Neonatorum

Due to Cerebral Hemorrhage

Due to Prematurity

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. H. Hodges M. D.
Address Union Mem. Hosp. Date signed 12/20/45

G35359

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G35359

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3901 - 5th St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3901 - 5th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas W. Gorman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Christine M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 4, 1885

8. AGE: Years	Months	Days	If less than one day
60	8	14	hr. min.

9. Birthplace Scotland (Town, county, and state)
10. Usual Occupation Engineer
11. Industry or business Shell Oil Co.

FATHER
12. Name John Gorman
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Margaret McIntyre
15. Birthplace Scotland

16 (a) Informant Christine M. Gorman
(b) Address 3901 - 5th St.

17 (a) Burial (b) Date thereof 12-21-1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location A. A. Co. Md.

18 (a) Funeral director Flynn & Fleming
(b) Address 1476 Light St.

19 (a) DEC 20 1945 (b) Huntington, Indiana
(Date received by local registrar) (Signature of local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 18 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 11 to 7 1945 to Dec. 18 1945, and that I last saw h alive on December 1945.

Immediate cause of death	Duration
Chronic Myocarditis	14 yr.
Due to Chr. Pulmonary Emphysema	4 yrs.
Due to	
Other Conditions Chronic Asthmatic Bronchitis	4 yrs.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature P. J. Ginnaldi, M. D.
Address 4609 Gor. Ritchie Date signed 12-18-45

VS 150

G35360 BOYLE

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48 B

G35360 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 403 Mt. Holly St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 403 Mt. Holly St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Boyle

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Peter James A. Boyle Sr.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 18, 1875

8. AGE: Years: 70 | Months: 6 | Days: 29 | If less than one day: hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation H. W.

11. Industry or business

FATHER
12. Name Mathew Dillon
13. Birthplace Ireland

MOTHER
14. Maiden Name
15. Birthplace Ireland

16 (a) Informant Thomas Boyle
(b) Address 403 Mt. Holly St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 21/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Rd.

18 (a) Funeral director Harry H. Mutsle
(b) Address 4101 Edmondson Ave

19 (a) (Date rec'd by registrar) (b) Registrar

DEC 21 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 17 1945, at 11:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1943, to Dec 17 1945 and that I last saw h[illegible] alive on Dec 17 1945.

Immediate cause of death: General Carcinomatosis

Duration: ?

Due to Carcinoma of uterus about 4 yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. P. Van Schaick M. D.
Address 4818 Edmondson Date signed 12/17/45

X and

G35561

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G35561 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo
(e) Length of stay in Baltimore (yrs., mos., or days) 1 mo

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County A A.
(c) City or town Salisbury
(If outside city or town limits, write RURAL and give town)
(d) Street No. —
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country —

3 (a) FULL NAME Catherine McGinnis

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	N	M

6 (b) Name of husband or wife Morgan —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — 1879

8. AGE: Years	Months	Days	If less than one day
56	—	—	— hr. — min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business —

FATHER
12. Name Ed Jackson
13. Birthplace Md.

MOTHER
14. Maiden Name Georgiana Booth
15. Birthplace Md.

16 (a) Informant Hospital Records
(b) Address University Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/23/45 (month) (day) (year)
(c) Cemetery or crematory Halls Memorial
Location A. A. Co. Md.

18 (a) Funeral director Isaiah L. Brown
(b) Address 108 W. Montgomery St.

19 (a) (Address) (b) Registrar

DEC 21 1945

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/19 1945, at 5:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/17 1945, to 12/19 1945, and that I last saw her alive on 12/19 1945.

Immediate cause of death Cardiac failure — Duration

Due to Hypertensive CVD

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: See above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature [illegible]
Address Univ. Hosp. Date signed M. 12 D. 19/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

635362

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

635362 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution: Monument St.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) 60 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3700 Chatham Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Wolf Levy

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Annie Levy

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years 70 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name
13. Birthplace Russia

MOTHER
14. Maiden Name
15. Birthplace Russia

16 (a) Informant Mrs. Annie Levy
(b) Address 3700 Chatham Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-21-45 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location

18 (a) Funeral director Jack Levine Inc
(b) Address 1439 E. Baltimore St

19 (a) (Signature of local registrar) (b) Date received by registrar DEC 21 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 20 1945 at 10:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 18 1945 to Dec 20 1945 and that I last saw him alive on Dec 20 1945

Immediate cause of death Cardiac failure — Duration

Due to Coronary occlusion & myocardial infarction

Due to Coronary sclerosis

Other Conditions Bronchial asthma

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Bertha Rader M. D.
Address Sinai Hospital Date signed 12/20/45

G35363

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

G35363 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & ff
(c) Hospital or institution: Sinai Hospt
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2528 Park Heights Ter.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Jerome Henkovitz (JEROME B. HERSKOVITS)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1921

8. AGE: Years 24 | Months | Days | If less than one day hr. min.

9. Birthplace New York City
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Louis Rubin

13. Birthplace Russia

MOTHER 14. Maiden Name Lottie Rubin

15. Birthplace Russia

16 (a) Informant Hosp Records

(b) Address

17 (a) Burial (b) Date thereof 12-24-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Rosedale

Location Rd & Hamilton Ave

18 (a) Funeral director Jack Levenberg

(b) Address 1439 E. Balto St

19 (a) DEC 21 1945 Huntington Hilliard M.D.
(Date rec'd by registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 19 1945, at 11:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 14 1945 to Dec. 19 1945 and that I last saw him alive on Dec. 19 1945.

Immediate cause of death Cachexia — Duration 1 month

Due to Fibromatosis (neural) — 9 years

Due to Multiple neurofibromatosis — 15 yrs

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Fibromatosis (neural)

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert Clemis M. D.

Address Sinai Hospital Date signed 12/20/45

X

G35364 | BALTIMORE CITY HEALTH DEPARTMENT | V G35364
CERTIFICATE OF DEATH 132 | Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 654 W. Fayette St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 654 W. Fayette St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine May Grasser

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) ~~Single, married~~, widowed, or divorced Widowed

6 (b) Name of husband ~~of~~ Henry Grasser

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years abt 60 | Months 3 | Days 9 | If less than one day hr. min.

9. Birthplace Albany N. Y.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Catherine "
15. Birthplace "

16 (a) Informant Catherine
(b) Address "

17 (a) Burial (b) Date thereof 12/22/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

19 (a) (b)
(Date filed by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 19th 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1945, to Dec 19 1945, and that I last saw h. Sr alive on Dec 13 1945

Immediate cause of death: Cardiac Arrest — Duration 3 days
Due to Nephritis? — Duration unknown
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm H Cooper M. D.
Address 4012 Edmondson Date signed 12/22/45

G35365

BALTIMORE CITY HEALTH DEPARTMENT ✓ G35365

CERTIFICATE OF DEATH 13B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 819 Burgundy st
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 819 Burgundy st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Joseph Perina

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Mar 17th 1907

8. AGE: Years	Months	Days	If less than one day
38	9	3	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Oiler
11. Industry or business Federal Tin Co.

FATHER
12. Name George Perina
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Margaret Burns
15. Birthplace Balto. Md.

16 (a) Informant Teresa May Weaver (Aunt)
(b) Address 819 Burgundy St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/22/45 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) (Date rec'd by registrar) (b) Registrar

DEC 21 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 20th 1945; at 3:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1st 1944 to Dec 20 1945, and that I last saw h alive on Dec 20, 1945

Immediate cause of death: Pulmonary Tuberculosis — Duration: 1 year

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature Harry E Kates

Address 517 Scott St. Date signed 12/20/45 M.D.

Harry E Kates X

G35366

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

9

G35366

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Herring Run & Harford Rd.
(c) Hospital or institution: Lydenham Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and name town)
(d) Street No. 1704 N. Charles St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Martha Leslie

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 31-1943

8. AGE: Years 2 Months 10 Days 18 If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Joseph Leslie
13. Birthplace Hillsborough, N.C.

MOTHER
14. Maiden Name Mildred
15. Birthplace Berry Point, N.C.

16 (a) Informant Mother
(b) Address 1704 N. Charles St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/22/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 317 St Paul St.

19 (a) (Date rec'd by registrar) (b) Registrar

DEC 21 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-18 1945 at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-17 1945 to 12-18 1945 and that I last saw h[illegible] alive on 12-18 1945.

Immediate cause of death Pertussis Encephalitis — Duration

Due to Pertussis

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Melchiph Spragins MD
Address Lydenham Hosp Date signed 12-19-45

X

Please write plainly, with unfading ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

635367

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170C

Registered No. 635367

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6704 Germanhill Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nicholas Soloman Lahti

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 213-07-3901

4. Sex: male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 7, 1903

8. AGE: Years 42 | Months 6 | Days 9 | If less than one day hr. min.

9. Birthplace Finland (Town, county, and state)

10. Usual Occupation Wire Mill

11. Industry or business Rustless Iron & Steel

FATHER — 12. Name ?

FATHER — 13. Birthplace Finland

MOTHER — 14. Maiden Name ?

MOTHER — 15. Birthplace Finland

16 (a) Informant Mrs. Minnie Maatta

(b) Address 6704 German Hill Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-21-45 (month) (day) (year)

(c) Cemetery or crematory Oak Lawn Cemetery

Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.

(b) Address NORTH AVE. & BROADWAY

19 (a) (b) L. Williams M.D. Registrar
(Date received by registrar)

DEC 21 1945

VS 191

MEDICAL CERTIFICATION

20. DATE OF DEATH December 16, 1945, at 6 55 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fractured Pelvis
Retroperitoneal Hemorrhage
Ruptured liver

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-15-45 12 30 a.m. 26/6
(b) Where did injury occur Dundalk Ave 18' north of Jones Rd.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian struck by

23. Signature Benedict Sbitarelli M.D. Medical Examiner.

Date signed 12-17-45.

D 35368.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 33a

G35368
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 803 N. Eden St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10-2
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 803 N. Eden St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jesse Kemp

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Viola Kemp
6 (c) If alive, give age 39 years

7. Birth date of deceased (mo., day, yr.) June 2nd 1895

8. AGE: Years	Months	Days	If less than one day
50	6	16	hr. min.

9. Birthplace Marion S. C. (Town, county, and state)
10. Usual Occupation Presser
11. Industry or business

FATHER
12. Name Frank Kemp.
13. Birthplace S. C.

MOTHER
14. Maiden Name Hanneley.
15. Birthplace S. C.

16 (a) Informant Viola Kemp
(b) Address 803 N. Eden St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-21st 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Balto. Co. Md.

18 (a) Funeral director Bryant Mamie Wright
(b) Address 725 Edgewood St

19 (a) (Registrar's signature) (b) Williams, Registrar

DEC 21 1945

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-18 1945 at 8 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-15 1945 to 12-18 1945 and that I last saw [illegible] alive on 12-18 1945

Immediate cause of death	Duration
Bronchio Pneumonia	3 days
Due to Influenza and	
Due to Acute Endocarditis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jas. R. Blake M. D.
Address 1327 N. Eden St Undersigned

X 12-20-45.

G35369

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 830

G35369 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto General
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 536 W. Pratt St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joshua White

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Separated

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ~~Feb. 22, 1895~~

8. AGE: Years 50 | Months 9 10 | Days 28 27 | If less than one day hr. min.

9. Birthplace: Calvert Co. Maryland (Town, county, and state)

10. Usual Occupation: Longshoreman

11. Industry or business

FATHER
12. Name: Gabriel White
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Eliza Johnson
15. Birthplace: Maryland

16 (a) Informant: Mrs. Alice A. Smith
(b) Address: 801 Pierce, Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-22-45 (month) (day) (year)
(c) Cemetery or crematory: MT. Auburn
Location: Baltimore MD.

18 (a) Funeral director: William A. Jackson
(b) Address: 916 Penna, Ave.

19 (a) DEC 21 1945 (Date received by Registrar) (b) Registrar: for Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/17/45, at 8:20 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy-Inquest thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Cerebral Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature B. L. Kubricht M.D. (Medical Examiner.)
Date signed 12/20/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35570

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

G35570 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution: Maryland General Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3135 N. Calvert St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Howard M. Addison

3 (b) If veteran, name war: None
3 (c) Social Security Account No. 212-07-5773

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Emma Swope Addison
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept. 12, 1882
8. AGE: Years 63 | Months 3 | Days 8 | If less than one day hr. min.
9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation President
11. Industry or business Spedden Shipbuilding Co.

FATHER
12. Name Samuel T. Addison
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary E.
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Emma S. Addison
(b) Address 3135 N. Calvert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/22/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Wm. J. Tickner & Sons, Inc.
(b) Address North & Pa. Aves. Balto. Md.

19 DEC 21 1945 (Date rec'd by local registrar) Huntington Williams M.D.

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/20 1945, at 9:A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/19 1945, to 12/20 1945, and that I last saw him alive on 12/20 1945.

Immediate cause of death	Duration
Cerebral Hemorrhage	24 hr.
Due to Hypertensive C.V. Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Martin E. Strobel M. D.
Address Md. Genl. Hospital Date signed 12/20/45

635371

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 44a

635371 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
U.S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3452 Elm Ave.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME
Jr. Mitchell, Joseph B.

3 (b) If veteran, name war: WW 2
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Evelyn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MARCH 29 1906

8. AGE: Years	Months	Days	If less than one day
39	8	21	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Iceman
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 21/45 (month) (day) (year)
(c) Cemetery or crematory St. Mary's
Location Hampden

18 (a) Funeral director Ehrenworth & Donovan
(b) Address 3115½ Eastern Ave

19 (a) (b)
(Signature of Registrar)
DEC 21 1945
For C. J. Koons, by Howard J. Maddux, Asst.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 19 1945, at 4:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 19 1945, to Dec 19 1945 and that I last saw him alive on Dec. 19 1945.

Immediate cause of death	Duration
Coronary thrombosis	A few hours
Due to Coronary sclerosis	UNKNOWN
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Wilson, Sr. Surgeon
Address Medical Director US Marine Hospital, Balto, Md.
Date signed 12/19/45 (M. D.)

635372

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

635372

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3510 Chestnut Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 6
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3510 Chestnut Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nettie K. Yeager.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: widow.

6 (b) Name of husband or wife: John H. Yeager

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 5, 1866

8. AGE: Years 79 | Months 3 | Days 14 | If less than one day ..... hr. ..... min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name George Metcalf
13. Birthplace Maryland.

MOTHER
14. Maiden Name Lavina Hamilton
15. Birthplace Maryland.

16 (a) Informant Mrs. Joseph Magaha.
(b) Address 3510 Chestnut Ave.

17 (a) Burial (b) Date thereof Dec 22/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Meadow Ridge
Location Washington Blvd.

18 (a) Funeral director Eichenlaub & Donovan
(b) Address 3615-17 Chestnut Ave

19 (a) DEC 21 1945 (b)
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 19, 1945 at 5 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1945 to Dec 19 1945 and that I last saw h[illegible] alive on Dec 19 1945

Immediate cause of death	Duration
Coronary Thrombosis	1 Day
Due to Chronic Valvular Heart Disease	5 Yrs.
Due to	
Other Conditions —	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature]
Address 3616 W 36th Pl Date signed 12/21/45

VS 130

Huntington Williams, M.D.

X

G35573

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G35573 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 17 N Gend St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 17 N Gend St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** David H. Bryant
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 8 1945

8. AGE: Years | Months | Days 7 | If less than one day hr. min.

9. Birthplace Balto Md. (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name Herbert A Bryant
13. Birthplace Indiana

MOTHER 14. Maiden Name Cora M. Harris
15. Birthplace Kentucky

16 (a) Informant Herbert A Bryant
(b) Address 17 N. Gend St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-21-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location

18. (a) Funeral director John C. Melby Inc
(b) Address 2435 E Oliver St

19 (a) Dec 21 1945 (Date of death) (b) Ira Williams (Physician or coroner)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 20 1945; at 7 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 15 1945 to Dec 19 1945. and that I last saw h alive on Dec 19 1945.

Immediate cause of death Premature Birth — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry Glassman M. D.
Address 753 W. Fayette St Date signed Dec 24

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35574

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G35574
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
U.S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Mass. (b) County
(c) City or town Boston
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6 Bridge Court
(If rural give location)
(e) Citizen of foreign country? yes (Yes or No)
If yes, name country Canada

3 (a) FULL NAME Dingwell, Frank Earl

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Gertrude Sheets
6 (c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr.) April 2, 1893

8. AGE: Years	Months	Days	If less than one day
52	8	17	hr. min.

9. Birthplace Prince Ed. Island, Canada
(Town, county, and state)
10. Usual Occupation Chief steward
11. Industry or business Seafarer

FATHER
12. Name Howard Dingwell
13. Birthplace Canada

MOTHER
14. Maiden Name Elizabeth Conroy
15. Birthplace Boston, Mass.

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 21. 45 (month) (day) (year)
(c) Cemetery or crematory Govans Presbyterian
Location York. Rd

18 (a) Funeral director Locke Funeral Home Inc
(b) Address 4644 York Rd

19 (a) (Filed) DEC 21 1945 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 19 1945, at 8:10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 17 1945 to Dec. 19 1945, and that I last saw him alive on Dec. 19 1945.

	Duration
Immediate cause of death Pneumonia, lobular	several days
Due to Bronchitis, severe with emphysema	several days
Due to Diphtheria	over
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Jr. Surgeon M. D.
Address Clinical Director Date signed
US Marine Hospital, Balto, Md.

VS 150

635375

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 99

635375 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Maryland Gen Hosp
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2700 Tivoli Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. William Franklin Bunce

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	married

6 (b) Name of husband or wife Christine Bunce
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 28-1905

8. AGE: Years	Months	Days	If less than one day
39	11	22	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Wholesale Produce
11. Industry or business

FATHER
12. Name Oliver Bunce
13. Birthplace

MOTHER
14. Maiden Name Annie Brook
15. Birthplace

16 (a) Informant Mrs. Christine Bunce
(b) Address 2700 Tivoli Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-21-43 (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Baltimore

18 (a) Funeral director Leonard J. Luck
(b) Address 5305 Norford Road.

19 (a) 12 21 1943 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-19 1943, at 4:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/10 1943, to 12/19 1943, and that I last saw him alive on 12-19 1943.

Immediate cause of death: Portal mesenteric thrombosis — Duration

Due to of the abdomen

Due to Buerger's Disease of the abdomen

Other Conditions Angiitis (generalized)
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Portal mesenteric thrombosis

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. H. Bryce, Jr. M. D.
Address Maryland Gen. Hosp. Date signed 12/19/43

G35376

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G35376 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green
(c) Hospital or institution: University 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore. (If outside city or town limits, write RURAL and give town)
(d) Street No. 422 Northwood Apts. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Anna T Turner TURNER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Lloyd L. Turner

6 (c) If alive, give age - years

7. Birth date of deceased (mo., day, yr.) Feb- -1897

8. AGE: Years 58 | Months 10 | Days | If less than one day ... hr. ... min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Wm H. Doyle

13. Birthplace Md, N.Y.

MOTHER 14. Maiden Name Helena Donnelly

15. Birthplace Md

16 (a) Informant Mrs. George L. Armstrong

(b) Address 422 Northwood Apts.-1

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-24-45 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Baltimore

18 (a) Funeral director Leonard J. Keuck

(b) Address 5805 Harford Road

19 (a) (b) Hunter for Williams, M.D.

DEC 21 1945 (Date rec'd by registrar) Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-20 1945, at 8:AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-15 1945, to 12-20 1945, and that I last saw her alive on 12-20 1945

Immediate cause of death	Duration
Respiratory Failure	
Due to Uremia	
Due to Cardiovascular renal disease	
Other Conditions Hypertension	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles L Butler M. D.

Address Union Hosp Date signed 12-22-45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35377

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1634 G35377

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dec
(e) Length of stay in Baltimore (yrs., mos., or days) 32 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1629 Gough St
(If rural give location)
(e) Citizen of foreign country? Poland (Yes or No)
If yes, name country

3 (a) FULL NAME Michael Maczyszenski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Eva Maszczenski

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 30 1892

8. AGE: Years	Months	Days	If less than one day
53	1	19	hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Joseph Maszczenski
13. Birthplace Poland

MOTHER
14. Maiden Name unknown
15. Birthplace Poland

16 (a) Informant Mrs Eva Maszczenski
(b) Address 1629 Gough Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 22 45 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary cem
Location Baltimore County

18 (a) Funeral director John M. Weber
(b) Address 401 E. Chester Street

DEC 21 1945 (Date received by Registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 19 1945, at 12 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy - Inquest thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Asphyxiation due to Carbon monoxide gas.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Dec. 19 at 1945 10A M.
(b) Where did injury occur? 1629 Gough St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Inhaled gas from stove

23. Signature Grant Lee Faehaven M.D.
Medical Examiner.
Date signed 12-19-45

VS 151

G35378

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓108

Registered No. G35378

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1631 Brunt St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 ~~2~~
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1631 Brunt St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James Allen

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widowed

6 (b) Name of husband or wife Bessie Allen
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Sept ? 1875

8. AGE: Years	Months	Days	If less than one day
70	3		hr. min.

9. Birthplace Va.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Aaron Allen
13. Birthplace Va.

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Aaron Allen
(b) Address 800 W Lexington St

17 (a) Burial (b) Date thereof 12/22/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md.

18 (a) Funeral director Geo. B. Kelson
(b) Address 1303 Presstman St

19 DEC 21 1945 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 19 1945, at 2.30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 17 1945, to Dec 19 1945, and that I last saw him alive on Dec 17 1945.

Immediate cause of death	Duration
Lobar Pneumonia	5 days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. William Fred M. D.
Address 1928 Penna Ave Date signed 12/20/45

G35379

AB-97927

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registrar's No. G35379

108

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 36 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 525 Orchard St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Harris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Hattie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 9-1906

8. AGE: Years	Months	Days	If less than one day
39	0	8	hr. min.

9. Birthplace N.C.
(Town, county, and state)
10. Usual Occupation Clerk-Baggage Room
11. Industry or business B. & O. Railroad Co.

FATHER
12. Name Bock Harris
13. Birthplace S.C.

MOTHER
14. Maiden Name McLean
15. Birthplace N.C.

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof Dec 21 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location
18 (a) Funeral director A. Halsted
(b) Address 9 E. Lanvale
19 (Signature) DEC 21 1945 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 17 1945, at 8.30P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-17 1945 to 12-17 1945 and that I last saw h im alive on 12-17 1945.

Immediate cause of death Lobar pneumonia — Duration 1

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Bilateral lobular pneumonia pleurisy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
Signature Margaret M. Davis
Address B. C. H. Date signed 12/20/45

X

G35380

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

TN. 97160 — 1103 — Registered G35380

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals 21
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-12 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1128 Russell St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Frances Jant

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 2nd. 1927

8. AGE: Years	Months	Days	If less than one day
18	10	17	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Edward Brown
13. Birthplace Maryland

MOTHER
14. Maiden Name Annie Williams
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/24/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary.
Location

18 (a) Funeral director Elroy A. Wilson
(b) Address 1000 Bradsley Ave

DEC 21 1945 (a) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 19th. 1945 19 11.10 at A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 7th 19 45 to Dec. 19 19 45 and that I last saw her alive on Dec. 19th 19 45

Immediate cause of death: Terminal bronchopneumonia — Duration: 2 days

Due to: Lung abscess & bronchopleural cutaneous fistula — 1 to 4 mos.

Due to: hydropneumothorax & atelectasis

Other Conditions: Grand mal epilepsy
(Include pregnancy within 3 months of death)

Date of operation 11-21-45

Major findings of operation: as above

of autopsy: none done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas J. O'Neill M. D.
Address Balto. City Hosps Date signed 12-20-45

G35381

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G35381

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 15 N. Durham St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 15 N. Durham St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marie Elsey Burton Faidley

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Col.	Married

6 (b) Name of husband or wife Robert Faidley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 5, 1897

8. AGE: Years	Months	Days	If less than one day
48	3	12	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name William Anderson
13. Birthplace Md.

MOTHER
14. Maiden Name Amelia Elsey
15. Birthplace Md.

16 (a) Informant Amelia Elsey
(b) Address 15 N. Durham St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-22-45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem.
Location

18 (a) Funeral director Elroy D. Wilson
(b) Address 1000 Brantley Rd
(c) Acting for Williams M.D.

DEC 21 1945
(Date rec'd by registrar) Registrar

12/17/45 **MEDICAL CERTIFICATION** 3:45 P.M.

20. DATE OF DEATH 12/17/45 19 . at 3:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1945 to Dec 1945 and that I last saw h[illegible] alive on Dec 17 1945.

Immediate cause of death — Duration

acute myocardial failure — 1 yr

Due to

Due to Chronic myocarditis

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature G. C. Burrell M. D.
Address 121 Aisquith Date signed 12/20/45

VS 150

G35382

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G35382 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 533 N. Bond St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 533 N. Bond St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Franklin Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	C.	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years	Months	Days	If less than one day
64			hr. min.

9. Birthplace Baltimore, Md.
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Henrietta Parker
(b) Address Camp Parole Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-21-45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem.
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Braddish ave

19 DEC 21 1945 Washington Williams, M.D. (Date filed by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 11 1945 at 6A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 2 1945 Dec 11 1945 and that I last saw h[illegible] alive on Dec 1945

Immediate cause of death: Acute Dilatation of Heart — Duration 18

Due to: Chr. Hypertension — 3 mos.

Due to: Hypertension — "

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. L. Lay Berry M. D.
Address 1420 E. Chase Date signed 12-20-45

VS 150

635383

BALTIMORE CITY HEALTH DEPARTMENT ✓ 635583
CERTIFICATE OF DEATH 46B Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 100 E. 23rd St.
(c) Hospital or institution: Mt. Harry Beck Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Yr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 100 E. 23rd St.
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Willie S. Creager

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Charles W.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 16-1880

8. AGE: Years 65 | Months 8 | Days 3 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name John Corbett
13. Birthplace Virginia

MOTHER 14. Maiden Name Ann Whitehead
15. Birthplace Virginia

16 (a) Informant Charles W. Creager
(b) Address 23 E. Ellwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 22-45 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Ave

18 (a) Funeral director John A. Logan
(b) Address 3010 E. Oak-A

DEC 21 1945
(Date rec'd by Registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 19 1945, at 4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 6 1945 to Dec 19 1945, and that I last saw h Dr alive on Dec 18 1945

	Duration
Immediate cause of death: Inanition	10 Days
Due to: Carcinoma of Stomach & Liver	3 Mos
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry S. Beck M. D.
Address 100 E 23rd St Date signed Dec. 19. 45

G35384

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G35384 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 709 N. Streeper, St.
(c) Hospital or institution: 7r
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 709 N. Streeper Street. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) **FULL NAME** Charles J. Zavadil.

3 (b) If veteran, name war: World War I.
3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married.

6 (b) Name of husband or wife: Antoinette M. Zavadil.
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) March 25, 1896

8. AGE: Years	Months	Days	If less than one day
49 yrs.	8	24	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Western Maryland.
11. Industry or business Millman.

FATHER
12. Name Henry Zavadil.
13. Birthplace Czechoslovakia.

MOTHER
14. Maiden Name Hujak.
15. Birthplace Czechoslovakia.

16 (a) Informant Wife.
(b) Address 709 N. Streeper Street.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 12/22/45 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Holy Redeemer
Location Belair Rd. Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street

DEC 21 1945 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/18/45 19 , at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 14 1945 to Dec 18 1945, and that I last saw him alive on Dec 10 1945

Immediate cause of death	Duration
Coronary Thrombosis	1 hr.
Due to	
Due to	
Other Conditions Arteriosclerosis	15 yrs.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature M. D.
Address 12/18/45 Date signed

G35385

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

G35385 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rukland & Laynor 3138
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2156 Druid Park Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME David Plummer — David Gilbert Plummer

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Divorced

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov. 7, 1902

8. AGE: Years	Months	Days	If less than one day
43	1	10	— hr. — min.

9. Birthplace Portage, Penna. (Town, county, and state)
10. Usual Occupation Machinist
11. Industry or business Bendix Radio Corp.

FATHER
12. Name Edward W. Plummer
13. Birthplace Portage, Penna.

MOTHER
14. Maiden Name Martha Fisher
15. Birthplace Portage, Penna.

16 (a) Informant Mrs. Hilda Wilkes
(b) Address Minneapolis, Minn.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 21, 1945 (month) (day) (year)
(c) Cemetery or crematory Prospect Hill
Location Towson, Md.

18 (a) Funeral director John Burns' Sons
(b) Address Towson, Md.

19 (a) Dec 21 1945 (Date rec'd by registrar) (b) Burial permit issued by William Hilly

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 17 1945, at 12 15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-15 1945, to 12-17 1945, and that I last saw h~~eard~~ alive on 12-17 1945

Immediate cause of death Pulmonary edema —

Due to Congestive Cardiac Failure

Due to Rheumatic Cardiac vascular disease - Mitral stenosis

Other Conditions Pneumonia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Myocardial Effusion

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Russell B. Lewis M. D.
Address West Baltimore General Hospital Date signed 12-18-45

635386

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 635386

CWK-97730

161a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 13-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr. 1 min.
(e) Length of stay in Baltimore (yrs., mos., or days) 1 hr. 1 min.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1550 Richland Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Girl Johnson.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 7-1945

8. AGE: Years	Months	Days	If less than one day
			1 hr. 1 min.

9. Birthplace Baltimore-Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Pearly Johnson
13. Birthplace Virginia

MOTHER
14. Maiden Name Margaret Harcum
15. Birthplace Virginia

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

19 DEC 21 1945 (Date received by Registrar) Huntington Williams, M.D. Registrar

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH December 7 1945 at 7 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 7 1945, to Dec. 7 1945, and that I last saw h.er alive on Dec. 7 1945.

	Duration
Immediate cause of death asphyxia	1 hr
Due to pulmonary atelectasis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: yes.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Otto S. Tobee M. D.
Address Date signed 12-14-45

635587

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

635587 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10'
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1112 Bruenmount
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Peter P Reilly

3 (b) If veteran, name war: Yes World War I
3 (c) Social Security Account No. 164-16-9535
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Florence M. Gunther Reilly
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 16 91
8. AGE: Years 54 | Months 5 | Days 3 | If less than one day hr. min.
9. Birthplace Iowa (Town, county, and state)
10. Usual Occupation Electrician
11. Industry or business Md Dry Dock

FATHER
12. Name John Reilly
13. Birthplace Ireland

MOTHER
14. Maiden Name Sarah Connelly
15. Birthplace Iowa

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 22/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4430 Belair Rd.
18 (a) Funeral director C. W. Conkling & Sons
(b) Address 924 E Eager St.
19 (a) (Date rec'd by registrar) (b) Registrar

DEC 27 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 19 1945 at 4 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from Dec 19 1945 to Dec 19 1945 and that I last saw h alive on Dec 19 1945
Immediate cause of death Pulmonia — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Great Wilmer M. D.
Address Johns Hopkins Hosp signed 12/19/45

635388 BALTIMORE CITY HEALTH DEPARTMENT ✓ 635388

CERTIFICATE OF DEATH 94a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address (Curtis Bay Works)
(c) Hospital or institution:
Davison Chemical Corp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 108 E. Birkhead St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country —

3 (a) FULL NAME William E. Cauffman

3 (b) If veteran, name war —

3 (c) Social Security Account No. 220-09-8740

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Ella M. Cauffman (nee Hollemister)
6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) Oct. 1, 1894

8. AGE: Years	Months	Days	If less than one day
51	2	19	....hr. ....min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Special Police Guard
11. Industry or business Davison Chemical Corporation

FATHER
12. Name Charles L. Cauffman
13. Birthplace Pr. Ga.

MOTHER
14. Maiden Name Elizabeth La Marr
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Ella M. Cauffman (Wife)
(b) Address 108 E. Birkhead St., Balto. 30, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 24, 1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore, Md.

18 (a) Funeral director R. Howard Evans
(b) Address 4005 Charles St., Balto 30, Md.

19 (a) (Date received by Registrar) DEC 21 1945 (b) Hunting Park Station

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 20 1945, at 2:40 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ....at ....M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed 12-20-45

635389

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

635389 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Give the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution:
Maryland General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1719 Resistatown Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Morris Vincent Chenowith

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Genevieve M. Chenowith
6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) July 24 1879

8. AGE: Years 66 | Months 5 | Days 26 | If less than one day ... hr. ... min.

9. Birthplace Baltimore Co. Md.
(Town, county, and state)

10. Usual Occupation Gardener

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) Burial (b) Date thereof 12/22/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Charles
Location Pikesville, Maryland

18 (a) Funeral director Frank A. Kerrill
(b) Address Pikesville, Maryland.

DEC 21 1945
(Date rec'd by local registrar)

(b) Signature for Williamson

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/20 19 45; at 11:35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/18 19 45; to 12/20 19 45; and that I last saw him alive on 12/20 19 45;

Immediate cause of death Bronchopneumonia — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Martin E. Strobel M. D.
Address Md. Gen'l Hospital Date signed 12/20/45

X

G35590

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

164E

G35590 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8½ mo
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 529 N. Linwood ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William C. Kommalan

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-05-2415

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Delma S.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 10, 1918

8. AGE: Years 27 | Months 3 | Days 7 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Aeronautical Mechanic

11. Industry or business

FATHER
12. Name George H. Kommalan
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Marie A. E. Menche
15. Birthplace Balto. Md.

16 (a) Informant Mr. Geo. H. A. Kommalan
(b) Address 21 Somerset Rd., Catonsville

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/20/45 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto, Md.

18 (a) Funeral director Namie C. Lyles
(b) Address 1600 N. Norfolk ave.

DEC 21 1945 (b)
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 17th 1945, at 10:30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐ PROBABLE homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of skull multiple fractures of ribs legs.

Due to Irrationality, history of

DUE TO: Other conditions Brain Abscess.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-17-45 at 10:25 P.M.
(b) Where did injury occur? Mercy
(c) Did injury occur at home, on farm, industrial place, in public place? Hospital While at work? no
(d) Means of injury Fall from window

23. Signature Robert Ch. Fletcher M.D.
Medical Examiner.
Date signed 12-19-45

(over)

G35391 BALTIMORE CITY HEALTH DEPARTMENT G35391

CERTIFICATE OF DEATH 51B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkins Aves.
(c) Hospital or institution:
St. Agnes Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 Days.
(e) Length of stay in Baltimore (yrs., mos., or days) 3 Days.

2. USUAL RESIDENCE OF DECEASED:
(a) State Canada. (b) County
(c) City or town Outremont, Montreal, Canada
(If outside city or town limits, write RURAL and give town)
(d) Street No. 876 Rockland Ave.
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Dom. of Canada.

3 (a) FULL NAME Hiram Moses Levinoff (HIRAM MOSES LEVINOFF)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married.

6 (b) Name of husband or wife Annie Levinoff.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) About 1881.

8. AGE: Years	Months	Days	If less than one day
About 64			hr. min.

9. Birthplace Russia.
(Town, county, and state)
10. Usual Occupation Real Estate Broker.
11. Industry or business

FATHER
12. Name Joseph Levinoff,
13. Birthplace Russia.

MOTHER
14. Maiden Name Sarah ?
15. Birthplace Russia.

16 (a) Informant Mrs. Annie Levinoff,
(b) Address Outremont, Montreal, Canada

17 (a) Removal & Burial thereof 12.21.45.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Chevra Kadisha
Location Montreal, Canada.

18 (a) Funeral director Harris Leonhardt & Son
(b) Address 1902 Eutaw Place.

19 (a) (Date rec'd by registrar) (b) Huntington Hillside, Md.

VS 150 DEC 21 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/Dec/ 1945 at 12:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/17/ 1945 to 12/20 1945.
and that I last saw h.. alive on 12/20 1945.

Immediate cause of death Cardiac failure

Duration

Due to Hypertension.
Cardio Vasc Disease

Due to

Other Conditions Ca ? prostate
Bone metastases
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Cliff Rasiff, M. D.
Address 22 Osgood Hosp. Date signed 12/20

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35592

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G35592 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3503 E Fairmount
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26-8
(e) Length of stay in Baltimore (yrs., mos., or days) 75 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3509 E Lombard (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dorothea Scheeler

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Theo H. Scheeler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 25, 1870

8. AGE: Years 75 | Months 3 | Days 25 | If less than one day ... hr. ... min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation
11. Industry or business At Home

FATHER 12. Name Geo Scheeler
13. Birthplace Germany

MOTHER 14. Maiden Name Barbara Schmidt
15. Birthplace Germany

16 (a) Informant Geo A Scheeler
(b) Address 3509 E Lombard

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 27 (month) (day) (year)
(c) Cemetery or crematory St Pauls Reformed
Location City

18 (a) Funeral director Lee & Kimmel Home
(b) Address 2108 Orleans St.

19 (a) ... (b) ... (Date rec'd by registrar) Huntington Hillsdale, Md. (Registrar)

VS DEC 21 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 19 1945, at 11 40 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1942 to Dec 19 1945 and that I last saw her alive on Dec 19 1945.

Immediate cause of death	Duration
Myocardial degeneration	
Due to Hypertensive heart disease	
Due to Hypertension	
Other Conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John J Gorsky
Address 147 East Ave Date signed 12-21-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35393 ✓ G35393

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N Caroline St
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 7 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 517 W Cumberland ST (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** VIOLA ~~Hohman~~ Hohman

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Divorced

6 (b) Name of husband or wife Geo Hohman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 11 88

8. AGE: Years	Months	Days	If less than one day
57	—	19	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Book Keeper
11. Industry or business

FATHER
12. Name Isaac McClelland
13. Birthplace Scotland

MOTHER
14. Maiden Name Mrs. Kinsley
15. Birthplace Scotland

16 (a) Informant Geo H Hohman
(b) Address 1913 N Castle St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 24 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location City

18 (a) Funeral director Ullrich Funeral Home
(b) Address 200 E Oreana St

19 (a) _____ (b) Huntington Williams, M.D. Registrar
(Date received by registrar) DEC 24 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 20 1945; at 4 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 17 1945 to Dec 20 1945 and that I last saw her alive on Dec 19 1945

Immediate cause of death	Duration
Cardiac Respiratory Failure	
Due to Cerebral Hemorrhage	
Due to Hypertensive Cardio-Vascular Renal	
Other Conditions Uterine Hernia	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Clemmens Mathews M.D.
Address St Joseph Hosp. Date signed 12/24/45

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

635394

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

635394 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 854 E.Pratt St.
(c) Hospital or institution:
3-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 854 E.Pratt St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Julius De Manss

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Rose
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 4 1880

8. AGE: Years	Months	Days	If less than one day
65	7	15	hr. min.

9. Birthplace Palermo Italy
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Rosario De Manss
13. Birthplace Italy

MOTHER
14. Maiden Name Rosalia ?
15. Birthplace Italy

16 (a) Informant Tony De Manss (Son
(b) Address 854 E.Pratt St.

17 (a) Burial (b) Date thereof Dec. 22/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Russell Della Russo
(b) Address 52 N.Morley St.

19 (a) (b)
(Date received by registrar) Registrar

DEC 21 1945

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 19 1945, at 9P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1 1945 to Dec 19 1945.
and that I last saw h[illegible] alive on Dec 19 1945.

Immediate cause of death	Duration
(a) Coronary thrombosis	2 weeks
Due to (b) Coronary Heart disease	1 yr
Due to (c) Hypertension	2
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature [illegible]
Address [illegible] Date signed 12/20/45 M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35595 JENKINS

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G35595

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Fleet Street
(c) Hospital or institution:
City Morgue 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days) 80 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 208 South Oldham Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Mary Jenkins

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Charles Jenkins
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 14 1853

8. AGE: Years	Months	Days	If less than one day
92	0	7	hr. min.

9. Birthplace England
(Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business at Home

FATHER
12. Name Unknown
13. Birthplace England

MOTHER
14. Maiden Name Unknown
15. Birthplace England

16 (a) Informant Martha Brushell daughter
(b) Address 208 S. Oldham st.

17 (a) Burial (b) Date thereof Dec. 24/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Brooklyn New York

18 (a) Funeral director Lilly & Gilerine
(b) Address 403 S. Wolfe st.

DEC 21 1945
(Date received by registrar) (b) Hunting for Hilton Bowie, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 21, 1945, at 11 A. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-vascular Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard A. Mueller M.D.
Medical Examiner.
Date signed 12-21-45

0 X

Rec'd

G35396

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G35396

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 600 Chapel Gate Lane
(c) Hospital or institution: Pine Crest Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 M
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and name town)
(d) Street No. 1813 Dover Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ozella Reed

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: John C. Reed
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug 22, 1879

8. AGE: Years 66 69 | Months 3 | Days 26 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John T. Howard
13. Birthplace Maryland

MOTHER
14. Maiden Name Unknown
15. Birthplace Maryland

16 (a) Informant George Reed
(b) Address 1813 Dover Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-22-45 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore Md.

18 (a) Funeral director George L. Schwab
(b) Address 2191 Frederick Ave.

19 (a) DEC 21 1945 (Or address of registrar) (b) Hunting for Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 20 1945; at 2:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1944, to Dec 20 1945, and that I last saw h[illegible] alive on 12/15 1945

Immediate cause of death: Rt Cerebral Hemorrhage — Duration: 1 day
Due to: Arteriosclerosis
Due to:
Other Conditions: Arteriosclerosis Hypertension
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:
23. Signature [illegible] M. D.
Address 53 26 Belvedere Ave. Date signed

X

635397

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

935 ✓

Registered No. 635397

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2543 Park Heights terrace
(c) Hospital or institution:

15-13

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 56 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2543 Park Heights Terrace
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Poltilove

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Ida
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1867

8. AGE: Years	Months	Days	If less than one day
78			hr. min.

9. Birthplace Russia
(Town, county, and state)
10. Usual Occupation
11. Industry or business Retired

FATHER
12. Name Hyman Poltilove
13. Birthplace Russia

MOTHER
14. Maiden Name Hannah ?
15. Birthplace Russia

16 (a) Informant Harvey G. Poltilove
(b) Address 2543 Park Heights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec, 21, 1945 (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cem
Location Hamilton Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) DEC 21 1945 (Date rec'd by Registrar) (b) Hunter for Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 21 1945, at 2 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from December 1944 to Dec. 21 1945 and that I last saw him alive on Dec. 21 1945

Immediate cause of death	Duration
Coronary Thrombosis	one day
Due to arteriosclerotic Heart disease	one year
Due to —	
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury

23. Signature Morris B. Schreiber M.D.
M. D.
Address 521 Fulton Ave Date signed 12-21-45

X

BAUER

635398

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 635398

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkins + Cutton Ave
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 734 W. Baltimore St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mrs Elizabeth Bauer

3 (b) If veteran, name war

3 (c) Social Security account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. widowed

6 (b) Name of husband or wife Lawrence H.

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug 28, 1860

8. AGE: Years 85 | Months 14 | Days 3 | 24 | Less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Peter Denzer

13. Birthplace Bavaria

MOTHER
14. Maiden Name Elizabeth

15. Birthplace Maryland

16 (a) Informant Son Frank Bauer

(b) Address 734 W Baltimore St.

17 (a) Burial (b) Date thereof 12-24-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer Cem

Location Baltimore Md

18 (a) Funeral director Eugene A Farley

(b) Address Fulton & Fayette

19 (a) (b) William Ba...
(Date received by Registrar)

DEC 27 1945 Hunting for William Ba...

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/21 1945 at 10:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/18 1945 to 12/21 1945 and that I last saw her alive on 12/21 1945.

Immediate cause of death	Duration
Cardiac failure	
Due to Hypertension - C-V Disease (Arteriosclerotic).	
Due to	
Other Conditions Bilateral Hydrothorax Pneumonia	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Max E. Goodman

Address 1 Mt. Vernon Pl. - Date signed 12/26/45

GB5399

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 127a

G35399
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Ouncland + Rayner St
(c) Hospital or institution:
West Baltimore General Hosp 21
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life 60yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1403 S. Carey St
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James H. Coleman

3 (b) If veteran, name war	3 (c) Social Security Account No. 213-05-6678

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Edna M. Good
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Feb 6, 1885

8. AGE: Years	Months	Days	If less than one day
60	10 11	14	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Paint Sprayer
11. Industry or business Glass Mfg.

FATHER
12. Name Walter S. Coleman
13. Birthplace Bgeto Md

MOTHER
14. Maiden Name Catherine Wheeler
15. Birthplace Baltimore Md

16 (a) Informant Edna M. Coleman
(b) Address 1403 S. Carey St -

17 (a) Burial (b) Date thereof 12/24/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3891 Frederick Rd

18 (a) Funeral director Johns J. Conway Home
(b) Address 961-03 Fallsway

DEC 21 1945
(Date received by local registrar)

(b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-20 * 1945 at 4:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/20 1945 to 12-20 1945 and that I last saw him alive on 12-20 1945 at 4:20 P.M.

Immediate cause of death	Duration
Right Ventricular Heart failure	
Due to Toxic Myocarditis	
Due to Gangrenous Cholecystitis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 12/20/45
Major findings of operation: Acute Gangrenous Cholecystitis
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Benjamin Berdansky M. D.
Address West Balto Gen'l Hosp Date signed 12/22/45

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35400

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 830

Registered No. G35400

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 221 S Mc. Curley St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20-7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 221 S. Mc. Curley St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary E. C. Groh

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex female | 5. Color or race white | 6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 15th 1865

8. AGE: Years 80 | Months 4 | Days 4 | If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation house work

11. Industry or business at home

FATHER
12. Name George F. Groh
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Elizabeth Koehler
15. Birthplace Washington D.C.

16 (a) Informant Miss Agnes R. Groh
(b) Address 221 S Mc. Curley St

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 12/21/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Road

18 (a) Funeral director John J. Cronin & Son
(b) Address 901-03 Hollins St

19 (a) DEC 21 1945 (Date received by Registrar) (b) Huntington Williams, M.D.

VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 19th 1945; at 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 19 1945 to Dec 19 1945 and that I last saw her alive on Dec 19 1945

Immediate cause of death: Cerebral Hemorrhage — Duration 4 hr

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. J. Cronin

Address 331 N. Freemont Date signed 12/20/45 M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35401 — BALTIMORE CITY HEALTH DEPARTMENT — G35401

CERTIFICATE OF DEATH 194a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2719 W. Baltimore St
(c) Hospital or institution: 20
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2719 W Baltimore St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Catherine B Keegan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex female | 5. Color or race white | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Late William C

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 12. 1869

8. AGE: Years 76 | Months 7 | Days 6 | If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Home work

11. Industry or business at home

FATHER 12. Name Michael J Pendergast

13. Birthplace Ireland

MOTHER 14. Maiden Name Bridget Conway

15. Birthplace Ireland

16 (a) Informant Miss Elizabeth Keegan

(b) Address 2719 W Baltimore St

17 (a) Loudon (Burial, cremation, or removal) (b) Date thereof 12/27/45 (month) (day) (year)

(c) Cemetery or crematory New Cathedral Location 4300 Old Frederick Rd

18 (a) Funeral director John J Gowan & Son

(b) Address 901-03 Hollins St

19 (a) (Date received by Local Registrar) (b) Huntington Williams, M.D. Registrar

DEC 21 1945

VS 169

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 18 1945 at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 15 1945 to Dec 18 1945 and that I last saw her alive on Dec 17 1945

Immediate cause of death Coronary Thrombosis — Duration

Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert Seagmeth M. D.

Address 1724 w Lombard St Date signed 12/20/45

X

635408

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1939

Registered No. 635408

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Please correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 507 Wyanoke Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 9 Days

2. USUAL RESIDENCE OF DECEASED:
(a) State Mass (b) County
(c) City or town Charlestown (If outside city or town limits, write RURAL and give town)
(d) Street No. 177 Chelsea St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: Eugene C. Driscoll

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Julia Cronin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years: About 73 | Months: -- | Days: -- | If less than one day: hr. min.

9. Birthplace: Mass (Town, county, and state)

10. Usual Occupation: Retired U. S. Postal
11. Industry or business: Employee

FATHER
12. Name: James Driscoll
13. Birthplace: Unobtainable

MOTHER
14. Maiden Name: Mary Savage
15. Birthplace: Unobtainable

16 (a) Informant: Mrs. Rosalie A. Davis
(b) Address: 507 Wyanoke AvE.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 12/24/45 (month) (day) (year)
(c) Cemetery or crematory: Holy Cross
Location: Malden, Mass

18 (a) Funeral director: K. W. Ahearn & Son
(b) Address: 805 N. Calvert St.

DEC 21 1945 (Registered by Registrar) (b) Hattie [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 21 Dec. 1945, at 11:50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 18 Dec. 1945, to 21 Dec 1945, and that I last saw h/M alive on 21 Dec. 1945.

	Duration
Immediate cause of death: BRONCHO-PNEUMONIA	3 DAYS.
Due to: CHRONIC MYOCARDITIS	6 MO.
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Lloyd E. Saylor M. D.
Address 3902 Greenmount Ave Date signed 21 Dec. 45

G35103

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

54a

Registered No. G35103

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greene & Redwood
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Fred
(c) City or town Rural Burkettsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Ella Mae Kann

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6, 1938

8. AGE: Years 7 | Months 7 | Days 16 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER 12. Name LeGrand Kann
13. Birthplace Md.

MOTHER 14. Maiden Name Sarah Roher
15. Birthplace Md

16 (a) Informant LeGrand Kann
(b) Address Burkettsville Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 24, 1945 (month) (day) (year)
(c) Cemetery or crematory Locust Valley
Location Near Burkettsville Md

18 (a) Funeral director L. H. Zentz & Bro
(b) Address Boonsboro Md

DEC 22 1945 (Date received by Registrar) Thurston Williams M.D. Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-21 1945 at 7:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/19 1945 to 12-21 1945, and that I last saw h[illegible] alive on 12/21 1945.

	Duration
Immediate cause of death Cerebral Oedema	
Due to Exploratory Operation for Medulloblastoma	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. R. McCauley Jr.

Address Junior Hosp. Date signed M. 12 D. 24 45

G35404

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G35404 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 504 N. Johnson Street
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days) 16 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 504 N. Johnson St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Barbara Brogden

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Fe	Colored	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 4, 1941

8. AGE: Years	Months	Days	If less than one day
		16	hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name Wm Seward Brogden
13. Birthplace Balto., Md

MOTHER
14. Maiden Name Mary Smith
15. Birthplace Balto Md

16 (a) Informant Mary Brogden
(b) Address 504 N. Johnson St

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School DEC 22 1945
18 (a) Funeral director Commissioner of Health
(b) Address
DEC 22 1945 (b) Signature Leon Williams MD
(Date rec'd by registrar)

V8 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 20 1945, at 3 P.M
21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 4 1945 to Dec. 20 1945, and that I last saw h[illegible] alive on Dec. 20 1945.

Immediate cause of death
Premature Infant
Due to Malnutrition
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration

Date of operation
Major findings of operations
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature R. W. Decklin Jr. M.D.
Address 426 N. Johnson Date signed 12/20/45

5160

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

635:05

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55E

635:05 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
U.S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 65 days
(e) Length of stay in Baltimore (yrs., mos., or days) 65 days

2. USUAL RESIDENCE OF DECEASED:
(a) State NY (b) County
(c) City or town Buffalo
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2030 Philmore Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Hall, Cleo

3 (b) If veteran, name war

3 (c) Social Security Account No. 105-10-0760

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 27, 1921

8. AGE: Years	Months	Days	If less than one day
24	3	24	hr. min.

9. Birthplace Sioux City, Iowa
(Town, county, and state)
10. Usual Occupation Radio operator
11. Industry or business Seafarer

FATHER
12. Name George W. Hall
13. Birthplace Iowa

MOTHER
14. Maiden Name Marie D. Peterson
15. Birthplace Denmark

16 (a) Informant Records
(b) Address US Marine Hospital

17 (a) Burial (b) Date thereof Dec 23, 45
(c) Cemetery or crematory Webster City Iowa
Location Webster City Iowa

18 (a) Funeral director Dodd Funeral Home Inc.
(b) Address 464 4th Ave. R.D.

19 Dec 22 1945 (b) Huntington, W. Va.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 21 1945, at 1:10PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 17 1945, to Dec. 21 1945, and that I last saw him alive on Dec. 21 1945.

Immediate cause of death Osteogenic sarcoma (primary left fibula) (amputated 1943) metastatic — Duration UNKNOWN
Due to to lungs, adrenals and other organs
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon M. D.
Address Clinical Director Date signed
US Marine Hospital, Balto, Md.

VS 180

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully verified. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35405

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

S.S. Bengal ✓ 186a

G35405

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Marine Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Uddevallangen 14 Skonstad
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country Sweden

3 (a) FULL NAME Karl A. Akelsson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	✓

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 11 1911

8. AGE: Years	Months	Days	If less than one day
34	-	8	hr. min.

9. Birthplace Skee Sweden
(Town, county, and state)

10. Usual Occupation Seaman

11. Industry or business

FATHER
12. Name unk.
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant
(b) Address

17 (a) Burial (b) Date thereof 12/20/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Rest Lawn Cem
Location Govans

18 (a) Funeral director Odea Funeral Home Inc
(b) Address 4644 York Rd

19 (a) [illegible] (b) Thursday for Williams
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 19 45 at 340 P.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fat embolism

Due to Compound fracture of leg, right

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-18-45 ? M.
(b) Where did injury occur? "S.S. Bengal" at sea
(c) Did injury occur at home, on farm, industrial place, in public place? on ship While at work?
(d) Means of injury Slipped and fell to deck

23. Signature Roland Lee Grafton M.D.
Medical Examiner.
Date signed Dec 20 1945

635:07

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. 635:07

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lower Canton
(c) Hospital or institution:
Baltimore City Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Lehouda
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Johan Pettersson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 28 1897

8. AGE: Years	Months	Days	If less than one day
53	-	22	hr. min.

9. Birthplace Bohult, Lenhagen Sweden
(Town, county, and state)

10. Usual Occupation Woman

11. Industry or business U.S.S. Holland

FATHER
12. Name "
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant
(b) Address

17 (a) Burial (b) Date thereof Dec. 22. 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Green Mount Presbyterian
Location York Rd

18 (a) Funeral director Odell Funeral Home Inc.
(b) Address 4644 York Rd

19 (a) DEC 23 1945 (b) Huntington Williams M.D.
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 20 1945, at 1:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 12-21-45

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35408

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G35408 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 13
(c) Hospital or institution: Union Memorial Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3614 Clipper Rd (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ernest H. Ruby

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 11-1945

8. AGE: Years | Months | Days 10 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name Ernest Abzed Ruby
13. Birthplace Maryland

MOTHER
14. Maiden Name Mildred V. Smith
15. Birthplace Maryland

16 (a) Informant Ernest A. Ruby
(b) Address 3614 Clipper Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 22 1945 (month) (day) (year)
(c) Cemetery or crematory St. Mary's Cemetery
Location Baltimore, Md.

18 (a) Funeral director Burgie-Hymond Home
(b) Address 2424 Falls Road

DEC 22 1945 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 21 1945 at 1145 M

I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Intestinal Pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Roland A. Graham M.D.
Medical Examiner.
Date signed 12-21-45

VS 151

G35:09

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G35:09

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1412 Morling Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 60 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1412 Morling Avenue
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Octavious Anderson

3 (b) If veteran, name war —

3 (c) Social Security Account No. 212-16-4430

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mary L. Anderson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 6-1870

8. AGE: Years 75 | Months 6 | Days 15 | If less than one day hr. min.

9. Birthplace Anne Arundel Co. Maryland (Town, county, and state)

10. Usual Occupation Painter

11. Industry or business

FATHER
12. Name Rodrick Anderson
13. Birthplace Maryland

MOTHER
14. Maiden Name Eliza Redmiles
15. Birthplace Maryland

16 (a) Informant Lewis P. Hunter
(b) Address 1412 Morling Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 24-1937 (month) (day) (year)

(c) Cemetery or crematory Moreland Memorial Park
Location Baltimore Co. Md.

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) DEC 23 1937 (Date received by registrar) (b) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 21- 1937, at 6:45 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-10 1937 to 12-20 1937 and that I last saw him alive on 12-20 1937

Immediate cause of death Cardiac decomp. — Duration 4 da.

Due to Arteriosclerosis CVD — 2

Due to —

Other Conditions, Influenza. — 4 da.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Laurence Abramowitz M. D.
Address 324 Dallas St Date signed 12-21-37

635110

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1312

Register No. 635110

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully written. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1301 N. Gilmor St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Parker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years	Months	Days	If less than one day
69			hr. min.

9. Birthplace
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School DEC 20 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 DEC 22 1945 (Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 8th 1945, at 3 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Chronic Pulmonary Tuberculosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard A. Williams M.D.
Medical Examiner.
Date signed 12/8/45

5164

G35411

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G35411

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 3

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5-0-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1633 E. Pratt St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur Barnum

3 (b) If veteran, name war –
3 (c) Social Security Account No. –

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	–

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years	Months	Days	If less than one day
75			hr. min.

9. Birthplace
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School DEC 20 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 DEC 22 1945 Howard Williams M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-9- 1937; at 10:15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Walders M.D.
Medical Examiner.
Date signed 12-10-37

1163

G35412

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G35412

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution: University Hospital 154
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 732 N. Cumberland St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Phillip Jones

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C.	S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 15 1945

8. AGE: Years	Months	Days	If less than one day
—	—	1	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name Edna Augusta Jones
15. Birthplace Balto., Md.

16 (a) Informant Edna Jones
(b) Address 732 N. Cumberland

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School DEC 20 1945 Commissioner of Health

18 (a) Funeral director
(b) Address

19 DEC 22 1945 (Registered by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 16 1945, at 10:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 15 1945, to Dec. 16 1945, and that I last saw him alive on Dec. 16 1945.

Immediate cause of death Atelectasis — Duration

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address Univ. Hosp. Date signed 14 Dec '45

VS 150

3162

G35413

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G35413

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2640 W. Franklin Street
(c) Hospital or institution:
20
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2640 W. Franklin Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William Richard Switzer Sr.

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Anna M. Switzer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 13, 1866

8. AGE: Years	Months	Days	If less than one day
79	0	7	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Unknown Switzer
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Wm. R. Switzer Jr.
(b) Address 2640 W. Franklin Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/24/45 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore, Maryland

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul Street

19 (a) DEC 29 1945 (Date rec'd by registrar) (b) Huntington for Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH December 20th 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 17 1945, to Dec. 20 1945 and that I last saw him alive on Dec. 19 1945.

Immediate cause of death: Arteriosclerotic Cardiovascular Disease — Duration
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lewis H. Kemp M. D.
Address 3030 Edmondson Ave. Date signed 12/21/45

VS 150

G35414

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G35414 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1219 Dukeland St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 D
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 1219 Dukeland St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME J. Carroll Boone

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: None

4. Sex: M
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: M.
6 (b) Name of husband or wife: Clara M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 2-1876

8. AGE: Years	Months	Days	If less than one day
69	7	19	hr. min.

9. Birthplace: Baltimore (Town, county, and state)
10. Usual Occupation: Md Institute for Blind
11. Industry or business:

FATHER
12. Name: Oliver Boone
13. Birthplace: ?

MOTHER
14. Maiden Name: ?
15. Birthplace: ?

16 (a) Informant: Mrs Clara Boone
(b) Address: 1219 Dukeland St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 12-24-45 (month) (day) (year)
(c) Cemetery or crematory: Greenmount
Location:

18 (a) Funeral director: Wm Cody Inc
(b) Address: 1217 St Paul St

19 (a) DEC 28 1945 (Date received by registrar) (b) Huntington Williams MD

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 21 1945, at 3 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-14-43 19 to 12-21-45 19, and that I last saw h[illegible] alive on 12-20 1945.

Immediate cause of death: Cerebral accident — Duration: 3 Days
Due to: Cerebrovascular hemorrhage and arteriosclerosis
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Harry S. Dembo M. D.
Address: 1268 Edmondson Date signed 12-26-45

VS 150

G35115

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

G35115 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 451 N. Ellwood Av
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town insert RURAL and give town)
(d) Street No. 457 N. Ellwood Av (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Casper Sr. Pettaliata

3 (b) If veteran, name war —

3 (c) Social Security Account No. 218-09-7986

4 Sex: Male

5 Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Venneta A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 12 - 1868

8. AGE: Years 77 | Months 4 | Days 19 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Revere Copper Co

FATHER
12. Name Anthony Pettaliata
13. Birthplace Italy

MOTHER
14. Maiden name Batistina Lanfredi
15. Birthplace Italy

16 (a) Informant A. Adelaide Pettaliata
(b) Address 457 N. Ellwood Av

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 24 45 (month) (day) (year)
(c) Cemetery or crematory Parkwood.
Location Taylor Av

18 (a) Funeral director John J. Moran
(b) Address 3610 E. Balto. St.

19 (a) (b) Date rec'd by registrar Huntington Williams Registrar

DEC 22 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 24 1945; at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 12 1945 to Dec. 24 1945, and that I last saw h alive on Dec. 20 1945

Immediate cause of death — Duration

Due to Hypostatic Pneumonia 2 days

Due to General Arterio Sclerosis 10 yrs.

Due to Myocardial Insuff. 5 yrs

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thos G. Nilan M. D.
Address 3 E. Biddle St Dec 27 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35416

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. G35416

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 127 Scott Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 127 Scott (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Susan Elliott

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. 220-20-8969

4. Sex Female | 5. Color or race White | 6 (a) Single, (Married) widowed, or divorced.

6 (b) Name of husband or wife Paul

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1905

8. AGE: Years 40 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace St Mary County (Town, county, and state)

10. Usual Occupation House work

11. Industry or business

FATHER
12. Name ?
13. Birthplace St Mary County

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Paul Ellyott
(b) Address 127 Scott St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 31-1945 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd

18 (a) Funeral director Joseph Cannalas
(b) Address 602 Wash. Blvd

19 (a) DEC 22 1945 (Date received by registrar) Wilmer J. Hunter Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 21 1945, 2:45 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Lobar Pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed 12-21-45

X

G35417

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

G35417 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division st
(c) Hospital or institution: Provident Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 93 days
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2229 Madison Ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME William Dickens

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	negro	widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? 1866

8. AGE: Years 79(7) | Months | Days | If less than one day hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation janitor

11. Industry or business

FATHER 12. Name Hezekiah Dickens

13. Birthplace Va

MOTHER 14. Maiden Name Mary Robinson

15. Birthplace Va

16 (a) Informant William H. White

(b) Address 2319 Madison Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 22 1945 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location Baltimore Md.

18 (a) Funeral director Wm. Ed. H. Otho Gant

(b) Address 163 Druid Hill Ave

19 (a) (b)

Registrar

DEC 22 1945

VS 168

MEDICAL CERTIFICATION

20. DATE OF DEATH December 19 1945 at 2.35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-7 1945 to 12-19 1945 and that I last saw h.r.m. alive on 12-19 1945.

Immediate cause of death cerebral hemorrhage

Due to Hypertensive arterio sclerotic Cardio vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

Yrs. Mos. Days

For hypertension for hemorrhage.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature J. D. Carr Jr. M. D.

Address Provident Hosp. Date signed 12/26/45

X

G35418

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G35418

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1632 N. Lexington St.
(c) Hospital or institution: Maryland Baptist Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1632 N. Lexington St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Williams

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife David A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 4, 1872

8. AGE: Years 73 | Months 9 | Days 15 | If less than one day hr. min.

9. Birthplace Scottsville, Va (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Peter Robinson

13. Birthplace Va

MOTHER 14. Maiden Name Malinda ?

15. Birthplace Va

16 (a) Informant Records: Maryland Baptist

(b) Address 1632 N. Lexington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 22, 1945 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location Baltimore, Md.

18 (a) Funeral director Mrs. Carl N. Holland

(b) Address 1631 Druid Hill Ave

19 (a) (b) Registrar

(Date rec'd by registrar) DEC 22 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 19 1945, at 8:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1940, to Dec 19 1945, and that I last saw h[illegible] alive on Dec. 19 1945.

Immediate cause of death: Pneumonia Flu

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: 5 days.

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thos A Johnson M. D.

Address 2329 Guilford Ave Date signed Dec 21 1945

Interim for Williams, M.D.

G35419

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183a

G35419 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully and correctly written. Do not abbreviate. Be sure to state the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline St.
(c) Hospital or institution: St. Joseph's Hospital 9-16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 18
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1629 E 31st St.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME J. Carl Schultz.

3 (b) If veteran, name war: 1st World War
3 (c) Social Security Account No. 192-05-6679

4. Sex: M.
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: married.
6 (b) Name of husband or wife: Viola
6 (c) If alive, give age: 60 years
7. Birth date of deceased (mo., day, yr.): Dec 27. 1896
8. AGE: Years 48 | Months 11 | Days 23 | If less than one day ... hr. ... min.
9. Birthplace: Baltimore (Town, county, and state)
10. Usual Occupation: Auditor
11. Industry or business:

FATHER
12. Name: Carl W. Schultz
13. Birthplace: Germany

MOTHER
14. Maiden Name: Helena Pidgeon
15. Birthplace: Baltimore Md

16 (a) Informant: Mrs Viola Schultz
(b) Address: 1629 E. 31st St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/22/45 (month) (day) (year)
(c) Cemetery or crematory: Pikewood Cem
Location: Taylor ave

18 (a) Funeral director: L. HECHMANN SON
(b) Address: 32 S. BROADWAY Huntington Williams

19 (a) DEC 22 1945 (Date received by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-19 1945 at 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-19 19 45 to 19; and that I last saw him alive on 12-19 19 45

Immediate cause of death	Duration
Respiratory failure	
Due to Cerebrovascular accident	
Due to Hypertension	
Other Conditions Cardiac murmur	

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm H. Spaeth M. D.
Address c/o St. Jos. Hosp. Date signed 12-20-45

VS 150

G35420

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G35420 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully written. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rakeland & Raymar
(c) Hospital or institution: West Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2523 Ashton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alva, Slacum — Alva R. Slacum

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife William J. Slacum
6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) January 10, 1893

8. AGE: Years	Months	Days	If less than one day
52	11	11	hr. min.

9. Birthplace Dorchester County, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER
12. Name James Goegehan
13. Birthplace Maryland

MOTHER
14. Maiden Name Unknown
15. Birthplace Maryland

16 (a) Informant Mr. William J. Slacum
(b) Address 2523 Ashton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 24, 1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Md.

18 (a) Funeral director Willis L. Monroe
(b) Address 1003 W. Baltimore St.

DEC 22 1945 (b) Huntington Wil Registrar
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 21 1945, at 11 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-20 1945 to 12-21 1945, and that I last saw h[illegible] alive on 12-21 1945

Immediate cause of death	Duration
Pulmonary edema	
Due to Acute R. Ventricular Failure	
Due to Bronchopneumonia	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy Pulmonary edema

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address West Baltimore General Hosp. signed 12-21-45

VS 150

635421 ✓1644 635421

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1426 Woodall St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days) 33 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1426 Woodall St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph H Nash Jr.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male. | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 22, 1912

8. AGE: Years: 33 | Months: 7 | Days: 27 | If less than one day: hr. min.

9. Birthplace Balto.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Joseph H Nash
13. Birthplace Balto.

MOTHER
14. Maiden Name Daisy Akers.
15. Birthplace Balto.

16 (a) Informant Joseph H. Nash.
(b) Address 1426 Woodall St.

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof 12-22-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem
Location 2930 Frederick Ave,

18 (a) Funeral director Chas. F. Dill.
(b) Address 1201 E. Fort Ave.

19 (a) DEC 22 1945 Waiting for Witness

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 19 1945 at 10½ M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 9 1945 to Dec 19 1945 and that I last saw [illegible] alive on Dec 19 1945.

Immediate cause of death: Acute Dilatation of Heart — Duration: 2 days
Due to: Bronchial Pneumonia — Duration: 10 da.
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature T. E. K. Campbell
Address 1644 Hanover St Date signed 12/26/45

VS 150

G35122

BALTIMORE CITY HEALTH DEPARTMENT Town 122 B Registered No. G35122

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Special attention is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2613 Pierpoint Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2613 Pierpoint Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Broadway Felder

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. 265-01-9619

4. Sex M | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Bradie Libby Mrs

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 15 1917

8. AGE: Years 28 | Months 4 | Days 5 | If less than one day hr. min.

9. Birthplace Manning S.C. (Town, county and state)

10. Usual Occupation Saloon

11. Industry or business

FATHER
12. Name Lemon Felder
13. Birthplace Manning S.C.

MOTHER
14. Maiden Name Mary Hamm
15. Birthplace Manning S C

16 (a) Informant Jack Miller
(b) Address 2426.5 Paca Street

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 12-22-45 (month) (day) (year)
(c) Cemetery or crematory Manning S C
Location

18 (a) Funeral director Isaiah L Runnels
(b) Address 108 W Montgomery St

19 (a) Date received by Registrar DEC 22 1945 (b) Signature for Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/25/1945 at 1:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/19/1945 to 12/25/1945 and that I last saw h alive on 12/25/1945

Immediate cause of death: Intestinal Obstruction — Duration 24 hrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. A. Loy M D
Address 1522 Harlem Ave Date signed 12/25/45

G35423

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G35423

Every item of information should be carefully supplied. Please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every correct age is especially important. Physicians: please write

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1726 n. Carey St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1726 n. Carey St
(e) Citizen of foreign country? (If naturalized, give location) No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary F. Stewart
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Fem. | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Chas. T. Stewart
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-6-73

8. AGE: Years 72 | Months 6 | Days 13 | If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business —

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mavis Stewart
(b) Address 1726 n. Carey St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/22/45 (month) (day) (year)
(c) Cemetery or crematory Arbutus
Location Md.

18 (a) Funeral director Geo. H. Kelson
(b) Address 1303 Freedman Pl.

DEC 22 1945 (Date received by Registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-19-1945, at 0 30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-12 1943 to 12-19-1945 and that I last saw h[illegible] alive on 12-18-1945

Immediate cause of death Cardio-renal-Vascular disease — Duration 2 yrs.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature George [illegible]
Address 1816 n. Monument St. M.D. Date signed 12-21-45

X (17)

G35424

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46a

G35424 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully corrected—age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1124 E. Lexington St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1124 E. Lexington St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rev. Mannie Nelson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	C.	MARRIED

6 (b) Name of husband or wife MARY
6 (c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) 12/25/1899

8. AGE: Years	Months	Days	If less than one day
45	11	24	hr. min.

9. Birthplace S. C. (Town, county, and state)
10. Usual Occupation Minister
11. Industry or business

FATHER 12. Name ? Nelson
FATHER 13. Birthplace S. C.

MOTHER 14. Maiden Name Mary ?
MOTHER 15. Birthplace S. C.

16 (a) Informant Mary Nelson
(b) Address 1124 Division St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/22/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A. C. County, Md.

18 (a) Funeral director Joseph B. Locke
(b) Address 1364 N. Central Ave

19 (a) (Date rec'd by registrar) (b) Registrar

DEC 22 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/19 1945 at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1945 to Dec. 19 1945.
and that I last saw him alive on Dec. 15 1945.

Immediate cause of death Carcinoma of the Oesophagus

Due to

Due to

Other Conditions Cachexia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Merrill G. Bing M.D.
Address 11 S. Arlington Ave Date signed 12/22/45

G354125 ✓ G354125

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1309 Valley St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1309 Valley St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Raphael N. French

3 (b) If veteran, name war: No.

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Margaret J. Donahue French

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 17, 1889

8. AGE: Years	Months	Days	If less than one day
56	2	3	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Supervisor at the
11. Industry or business Standard Oil Co.

FATHER
12. Name Thomas J. French
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret Butler
15. Birthplace Ireland

16 (a) Informant Mrs. Margaret J. French
(b) Address 1309 Valley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 24/45 (month) (day) (year)
(c) Cemetery or crematory Mount Cathedral Cem.
Location 4300 Old Frederick Rd.

18 (a) Funeral director Elmer W. Conteline, Son
(b) Address 924 E. Eager St.

19 (a) (Date rec'd by registrar) (b) Registrar

DEC 22 1945 Huntington Willis

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 20 1945, at 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 3/21 1945 to 12/20 1945 and that I last saw him alive on 12/19 1945.

Immediate cause of death: Coronary Thrombosis — Duration Sudden

Due to: Arteriosclerotic Cardio

Due to: Vascular Renal Disease — Duration ?

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph L. Blum

Address 1206 E. Preston Date signed 12/24/45 M.D.

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35426

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

G35426 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1137 Fillmore St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1137 Fillmore St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Robert E. L. Hughes

3 (b) If veteran, name war: No

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Isabella J. Hughes 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 2. 1890

8. AGE: Years 55 | Months 3 | Days 18 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Maintenance Man

11. Industry or business Central Continental Corp.

FATHER 12. Name Franklin P. Hughes
13. Birthplace Baltimore Md.

MOTHER 14. Maiden Name Elizabeth Pinkerton
15. Birthplace Baltimore Md.

16 (a) Informant Mrs. Margaret M. Hughes
(b) Address 1137 Fillmore St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 24/45 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cemetery
Location: 3310 Gaylor Ave.

18 (a) Funeral director Edward W. Conkling & Son
(b) Address 924 E. Lager St.

19 (a) (Date rec'd by registrar) (b) Registrar

DEC 22 1945 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 20, 1945, at 5 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 3rd. 45. to Dec. 20th 45. and that I last saw h IM alive on Dec. 19th 45.

Immediate cause of death: Carcinoma of Liver — Duration: 21 weeks

Due to: ------

Due to: -------

Other Conditions: none

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged, statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. W. Murgatroyd M.D.

Address 401 E. 25th. St. Date signed M 12 D 21/45

X

G35427

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G35427 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2704 Edmondson Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 -
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2704 Edmondson Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Wesley Green

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/21/1862

8. AGE: Years	Months	Days	If less than one day
83	9	29	hr. min.

9. Birthplace Washington DC. (Town, county, and state)
10. Usual Occupation None.
11. Industry or business

FATHER
12. Name Frank A. Green
13. Birthplace unknown

MOTHER
14. Maiden Name Harriet White
15. Birthplace unknown

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/24/45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address North Ave. & Pa. Ave.

19 DEC 22 1945 (Date received by Registrar) (b) Inserting for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/20 1945, 12 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1945 to 12-20 1945 and that I last saw h. her alive on Dec 20 1945

Immediate cause of death: Myocardial Degeneration — Duration
Acute coronary occlusion type heart dis. with hypertrophy & congestive failure. — several days
Due to
Due to Generalized arteriosclerosis — Years.

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Winchel M. D.
Address 2901 Edmondson Ave Date signed Dec 21 1945

VS 150

635128

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 635128

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 302 E. 22nd St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) 3 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 302 E. 22nd St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ralph Nicholson Webster

3 (b) If veteran, name war	3 (c) Social Security Account No.
World War 1	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Adelle Marie Webster
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 25, 1887

8. AGE: Years	Months	Days	If less than one day
58	0	26	hr. min.

9. Birthplace Chicago, Ill
(Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business Social Security Board

FATHER
12. Name Thomas Webster
13. Birthplace England

MOTHER
14. Maiden Name Anna Martindale
15. Birthplace England

16 (a) Informant Mrs. Robert D. Carson
(b) Address 302 E. 22nd St. Baltimore

17 (a) Removal (b) Date thereof 12/22/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Forest Rose
Location Lancaster, Ohio

18 (a) Funeral director Wm. J. Tickner & Sons, Inc
(b) Address North & Pa. Aves. Baltimore

19 (a) (Date rec'd by registrar) 1945 (b) Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH December 19, 1945, at 1:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 18 1945 to Dec 19 1945 and that I last saw h[illegible] alive on Dec 18 1945

Immediate cause of death Coronary Thrombosis

Due to Arterial Sclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

Duration 24 hrs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. N. Pearce M. D.
Address 2104 Clark Rd Date signed Dec 20/45

VS 150

G35429

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G35429
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address North Calvert St.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 18 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2918 Rosalie Aver (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Lelia Pearl Zimmerman

3 (b) If veteran, name war: no

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Raymond W. Zimmerman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 27-1886

8. AGE: Years 59 | Months 9 | Days 23 | If less than one day hr. min.

9. Birthplace New Market, Va. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Peter Dingo
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Vogel
15. Birthplace Maryland

16 (a) Informant: Mr. Raymond W. Zimmerman
(b) Address 2918 Rosalie Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/24/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Hope Cemetery
Location Woodsboro, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19. (a) 12 22 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 20 1945, at 9:33 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-17 1945, to 12-20 1945, and that I last saw her alive on 12-20 1945.

	Duration
Immediate cause of death: Congestive Heart Failure with Pulmonary Edema	12 hrs
Due to: Uremia	4 days
Due to: Hypertensive Cardio-Vascular Renal Disease	4 Years
Other Conditions: Diabetes mild	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph E. Redd M. D.
Address Mercy Hospital Date signed 12-20-45

VS 150

937

Dr Brennan 635-30
5718 Harford Rd

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

97 Registered No. 635-30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5718 Harford Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 64
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5718 Harford Road. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Stockman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	WIDOW

6 (b) Name of husband or wife Joseph C.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 13 - 1877

8. AGE: Years	Months	Days	If less than one day: hr.	min.
68	3	7		

9. Birthplace Balto Co. Md. (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER 12. Name Peter Emge
13. Birthplace Md

MOTHER 14. Maiden Name Anna Beyer
15. Birthplace Md.

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-24-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Leonard J. Keuck
(b) Address 5305 Harford Rd.

19 (d) DEC 22 1945 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 20, 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 19 1945 to Dec 20 1945 and that I last saw h e alive on Dec 19 1945

Immediate cause of death Cardiac failure — Duration
Due to Arteriosclerosis generalized.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas J. Brennan M. D.
Address 5217 Harford Rd Date signed 12-27-45

VS 150

Huntington Williams, Md

G35431

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48B

Registered No. G35431

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully and fully given. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address St. Joseph's
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4203 Nicolas Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mary C. Rider

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	M.

6 (b) Name of husband or wife Jacob F.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 18-1891

8. AGE: Years	Months	Days	If less than one day
54	1	4	hr. min.

9. Birthplace Harford Co. (Town, county and state)

10. Usual Occupation at home.

11. Industry or business

FATHER 12. Name Sheffields

13. Birthplace Harford Co.

MOTHER 14. Maiden Name Callie Pettit

15. Birthplace Harford Co.

16 (a) Informant Mr. Jacob F. Rider

(b) Address 4203 Nicolas Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-24-45 (month) (day) (year)

(c) Cemetery or crematory Cooptown Cem

Location

18 (a) Funeral director Leonard Jokuck

(b) Address 5305 Harford Rd.

DEC 22 1945 (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-22 1945 at 3:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-14 1945 to 12-22 1945 and that I last saw h alive on 12-21 1945

Immediate cause of death	Duration
Cardiac Failure	
Due to Carcinomatosis	
Due to Cancer of the uterus	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm H. Frank M. D.

Address c/o St. Jos. Hosp. Date signed 12-22-45

VS 150

G35432

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G35432 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 64 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 330 E 26th St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine O'Brien

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 28, 1865

8. AGE: Years 80 | Months 5 | Days 3 | If less than one day hr. min.

9. Birthplace England. (Town, county, and state)

10. Usual Occupation home

11. Industry or business —

FATHER 12. Name John M. O'Brien
13. Birthplace Ireland

MOTHER 14. Maiden Name Susan Davis
15. Birthplace Scotland

16 (a) Informant John O. Brien
(b) Address 330 E 26th St. Balto.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-24-45 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto.

18 (a) Funeral director Leonard J. Luck
(b) Address 5305 Harford Road

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH December 21 1945, at 8:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 21 1945, to Dec. 21 1945, and that I last saw h.e.r. alive on Dec. 21 1945

Immediate cause of death Pneumonia
Cerebro-Vascular Collapse

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration Not Known

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Saunders Jr. M.D.
Address Mercy Hospital Date signed 12/24/45

VS 150

G35433

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G35433

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 123 S. Soppleton St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 - 9
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 123 S. Soppleton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William E. Klingmeyer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Rosa E. Klingmeyer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 15, 1873

8. AGE: Years 72 | Months 3 | Days 6 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Bar Maker

11. Industry or business Retired

FATHER
12. Name William Klingmeyer
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Duemeyer
15. Birthplace Germany

16 (a) Informant Mrs Rosa E Klingmeyer
(b) Address 123 N. Soppleton Street

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 12/24/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location 4300 Old Frederick Road

18 (a) Funeral director John E Cowan & Son
(b) Address 901-09 E Fallsway

DEC 22 1945 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 188

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 21st 1945, at 8:04 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 2, 1945 to Dec. 21, 1945 and that I last saw him alive on Dec. 20, 1945

Immediate cause of death: Congestive Heart Failure — Duration: 48 hrs.

Due to: Arteria Sclerotic Cardio-vascular Disease

Due to:

Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operations: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thos. Norton, Jr.
Address Bon Secours Hosp. Date signed 12/21/45 M. D.

X

G36134

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G35134 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution: Maryland General 20
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 1/2 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 8

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4200 Moss. Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William W. Zeller

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Diane Zeller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 21 1899

8. AGE: Years	Months	Days	If less than one day
46	10	15	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Sheet Metal Contract
11. Industry or business William W. Zeller, Co

FATHER
12. Name Wm. F. Zeller
13. Birthplace Md

MOTHER
14. Maiden Name Mary A Zeller
15. Birthplace Md

16 (a) Informant Diane Zeller
(b) Address 4200 Moss Ave

17 (a) Burial (b) Date thereof Dec 22 '45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location

18 (a) Funeral director Henry K Wright
(b) Address 4101 Eastern Ave

19 (a) DEC 22 1945
(Date received by registrar) Registrar
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/19 1945; at 11 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/19 1945 to 12/19 1945; and that I last saw h[illegible] alive on 12/19 1945

Immediate cause of death	Duration
Cerebral Hemorrhage	7 hrs
Due to Hypertensive C.V. Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Martin E. Strobel M. D.
Address Md. Gen'l Hospital Date signed 12/19/45

G35435

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

Registered No. G35435

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3616 McTavish Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3616 Mc Tavish Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Frieda Mueller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: W.

6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: Late Louis G.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 26, 1862

8. AGE: Years 83 | Months 3 | Days 24 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation H. W.

11. Industry or business

FATHER
12. Name Faehrenbach
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Louis A. Mueller—Son
(b) Address 3610 McTavish Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/22/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location 3801 Frederick Rd

18 (a) Funeral director Harry H. Nitske
(b) Address 4016 Edmondson Ave

19 (a) (Date rec'd by registrar) (b) Registrar

DEC 22 1945

VS 156

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 20 1945, at 7:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 12 1945 to Dec 20 1945 and that I last saw h[illegible] alive on Dec 19 1945.

Immediate cause of death: Bronchopneumonia, Degen. Arterio sclerotic type heart disease with hypertrophy

Due to: and congestive failure

Due to: Generalized arterio sclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: Several years.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Michel

Address 4401 Edmondson Ave Date signed Dec 21 45 M. D.

X

6354436

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. 6354436

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2033 E. 30th Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2033 E. 30th Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CARRIE ESTELL DAUGHERTY

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 28, 1872

8. AGE: Years	Months	Days	If less than one day
73	4	22	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation School Teaching- retired
11. Industry or business

FATHER
12. Name James Dickenson
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Mary Taylor
15. Birthplace St. Mary's County

16 (a) Informant Mrs. Foxwell
(b) Address 1808 Chilton Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-22-45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) 12-22-1945 (b) Huntington Williams
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 20 1945, at 3 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 1940 to Dec. 19 1945, and that I last saw him alive on Dec. 19 1945.

Immediate cause of death	Duration
Myocarditis	years
Due to Arteriosclerosis Generalized	years
Due to	
Other Conditions Hypertension	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry M. Hanson M. D.
Address 32 E. Saratoga St. Date signed 12/26/45

VS 150

G35437

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

Registered No. G35437

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 412 N. Chester St
(c) Hospital or institution John Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 412 N Chester St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louisa Pohler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Herman Pohler

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 28 1855

8. AGE: Years	Months	Days	If less than one day
89	11	18	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Wm. Ruths
13. Birthplace Germany

MOTHER
14. Maiden Name Not Known
15. Birthplace Not Known

16 (a) Informant Harry R. Pohler
(b) Address 412 N. Chester St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 22-45 (month) (day) (year)
(c) Cemetery or crematory Balto. Cemetery
Location North Ave. & Gay St.

18 (a) Funeral director John A. Miller
(b) Address 2334 Jefferson St.

17 (a) Dec 22 1945 (b) Registrar Lexington Williams MD Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 20 Dec 1945, at 1 45 M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Wellborn DeHaven Gibbs M.D. Medical Examiner
Date signed 20 Dec 45

G35438

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G35438 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1512 Ashland Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 d
(e) Length of stay in Baltimore (yrs., mos., or days) 23 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1512 Ashland Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Ray

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Annie G. Ray

6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) June 11th 89

8. AGE: Years 54 | Months 6 | Days 21 | If less than one day hr. min.

9. Birthplace Raleigh N. C.
(Town, county, and state)

10. Usual Occupation Barber

11. Industry or business

FATHER 12. Name Andrew Ray
13. Birthplace N. C.

MOTHER 14. Maiden Name Alice
15. Birthplace N. C.

16 (a) Informant Annie G. Ray
(b) Address 1512 Ashland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-22-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Balto. Co. Md.

18 (a) Funeral director Bolton Francis A. Knight
(b) Address 121 Aisquith St

19 (a) 1945 (b) Huntington Williams M.D.
(Date received by registrar) Registrar

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 19th 1945 11:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/8/45 19 to 12/19 1945
and that I last saw him alive on 12/19 1945.

Immediate cause of death Coronary Occlusion — Duration 1 day

Due to Diabetes Mellitus

Due to Hypertension

Other Conditions Cardiorenal

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert L. Leopard M. D.
Address 822 N. Broadway Date signed 12/22/45

635139

635139

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157 C

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 36 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 36 hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3024 Woodland Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Pauline Rosenbach

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 20, 1945

8. AGE: Years | Months | Days | If less than one day 36 hr. — min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation
11. Industry or business —

FATHER: 12. Name Philip Rosenbach
13. Birthplace Baltimore Md

MOTHER: 14. Maiden Name Mary Clara Gaither
15. Birthplace Baltimore Md.

16 (a) Informant Mary Clara Gaither
(b) Address 3024 Woodland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/22/45 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto. City

18 (a) Funeral director C. Vernon Lemmon
(b) Address Walbrook Park (Reisterstown Md)

DEC 29 1945 (Date received by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/21 1945 at 2:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/20 1945 to 12/21 1945, and that I last saw h[illegible] alive on 12/21 1945

Immediate cause of death Pneumonia, influenza

Due to Congestive heart failure (Due to, if any, stating the first, second, etc., conditions, if there were such)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

Duration
3 hr
36 hrs

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Vincent B. Fitzpatrick Jr.
Address Maryland Hosp Date signed 12/26/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G35440 BALTIMORE CITY HEALTH DEPARTMENT G35440
CERTIFICATE OF DEATH 183a Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1509 W. Lanvale St.
(c) Hospital or institution: —
16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 68 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1509 W. Lanvale St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Julia Jeffries

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Daniel Jeffries.
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Apr. 9 1859

8. AGE: Years 86 | Months 8 | Days 7 | If less than one day — hr. — min.

9. Birthplace Petersburg, Va
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Jesse Diggs.
13. Birthplace Petersburg, Va.

MOTHER
14. Maiden Name Lucy Thompson
15. Birthplace Va.

16 (a) Informant Mrs. Edna Grooms
(b) Address 509 W. Lanvale St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-24-1945 (month, day) (year)
(c) Cemetery or crematory Arlington Cemetery
Location Halethorpe, Md.

18 (a) Funeral director George T. Gelson
(b) Address 735 Druid Hill Ave

19 (a) DEC 27 1945 (Date rec'd by registrar) (Huntington Williams, M.D. Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 24 1945, at 7.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 2 1935 to Dec. 24 1945, and that I last saw her alive on 12-20 1945.

Immediate cause of death: Cerebral Hemorrhage — Duration 3 days
Due to Hypertension & Chronic Nephritis — 7 yrs
Due to —
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operations: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work? —
(e) Means of injury —

23. Signature C. N. Diggs, M. D.
Address 5366 Lanvale St Date signed 12-27-45

VS 3

G35441

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G35441 Registered No. 1310

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dukeland & Raymond
(c) Hospital or institution: Mt Wash. Gen Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Waltherope
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1706 Selma Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie B. Carter

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife George J. Carter
6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) April 28 1900

8. AGE: Years 45 | Months 7 | Days 23 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Wife
11. Industry or business

FATHER
12. Name John M. Brohawn
13. Birthplace Md

MOTHER
14. Maiden Name Annie Stokes
15. Birthplace Georgia

16 (a) Informant George J. Carter
(b) Address 706 Selma Ave Waltherope Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 24 1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk
Location Baltimore City

18 (a) Funeral director Hall & B. M. Walter
(b) Address Pratt & Fulton Sts

19 (a) (Signature of local registrar) (b) Huntington Williams M.D.

DEC 22 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 21 December 1945 at 10:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 21 Dec 1945 to 21 Dec 1945, and that I last saw h e alive on 21 Dec 1945.

Immediate cause of death: Resp Failure — Duration

Due to Carbolic Poisoning Accidental Inhalation — Duration

Due to Hydrochloric C.V. Acid Burns — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)
Date of operation Aug 27 1945
Major findings of operation: Carbolism — funeral at Sep. Hosp.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hub C Hall M. D.
Address Mt Wash Gen Hosp. Date signed 21 Dec 45

G35442

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 178 B

G35442
Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Loch Raven Blvd & 25th St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1222 Hollins St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George A. Schmidt

3 (b) If veteran, name war None
3 (c) Social Security Account No. 215-10-6827

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Pauline M.
6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) Sept 13 1906

8. AGE: Years	Months	Days	If less than one day
39	3	6	hr. min.

9. Birthplace Baltimore Md
(town, county, and state)
10. Usual Occupation Chauffer
11. Industry or business Eastern Sales Truckers

FATHER
12. Name Christopher Schmidt
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Engelhardt
15. Birthplace Germany

16 (a) Informant Pauline M. Schmidt
(b) Address 1222 Hollins St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 22-1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location City

18 (a) Funeral director Raff C. & B.M. Walters
(b) Address Platts Chicken St

19 Dec 22 1945 (b) Huntington Williams
(Date received by local registrar) (Signature of local registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 19 1945 at 5:30 PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Asphyxiation

Due to Carbon monoxide poisoning

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ causes of death, fill in the following: 9/8
(a) Date of injury December 19 1945 M.
(b) Where did injury occur Loch Raven Blvd & 25 St.
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury Carbon Monoxide Asphyxiation

23. Signature Benedict Skitarelis M.D.
Medical Examiner.
Date signed 12-20-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

G35443

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No. G35443

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1601 Edmondson Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1601 Edmondson Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mamie V. Brooks West

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4 Sex Female | 5 Color or race Colored | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Edward West
6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.) Nov 2, 1891

8. AGE: Years 54 | Months 1 | Days 17 | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER
12. Name Abraham Brooks
13. Birthplace Balto Md

MOTHER
14. Maiden Name Jennie Henry
15. Birthplace Cape Charles Va

16 (a) Informant Robt. Earl Anderson
(b) Address 1601 Edmondson Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 23 '45 (month) (day) (year)
(c) Cemetery or crematory Arlington Memorial
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St

19 DEC 22 1945 (Date received by local reg.) Huntington Williams M.D. (Signature of local registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 19 1945 7:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 10 1945 to Dec 19 1945 and that I last saw h.er alive on Dec 19, 1945

	Duration
Immediate cause of death: Cerebral hemorrhage	
Due to: Hypertensive Cardio Vascular Renal Dis.	
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. A. Harris M. D.
Address 1601 E Arrow Ed Ave Date signed 12/22/45

G35444

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55E

Registered No. G35444

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1305 Springdale Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Isadore Miller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Sophie

6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.) 7-3-99

8. AGE: Years 46 | Months 5 | Days 21 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Brewery

11. Industry or business

FATHER 12. Name Louis Miller

13. Birthplace Russia

MOTHER 14. Maiden Name Sarah Mankowitz

15. Birthplace Russia

16 (a) Informant JOHNS HOPKINS HOSPITAL

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 26/45 (month), (day), (year)

(c) Cemetery or crematory Hebrew Friendship

Location 360 E Balto st

18 (a) Funeral director Sol Levinson & Bros

(b) Address 1426 W. North ave

DEC 26 1945 (Date rec'd by registrar)

(b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 24 1945, at 10:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 23 1945, to Dec 24 1945 and that I last saw h alive on Dec 24 1945

Immediate cause of death Cardiac failure — Duration 6 hrs

Due to Lymphosarcoma — 1 yr.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature William Russell Jr. M. D.

Address Johns Hopkins Hosp. Date signed 12-24-45

VS 150

G35145

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1046

G35145 Registered No.

Please write plainly, with unfading ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 12
(c) Hospital or institution: Johns Hopkins Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 124 W. 22nd St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gilbert Underwood

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col.	—

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1, 1945

8. AGE: Years	Months	Days	If less than one day
	6	19	hr. min.

9. Birthplace Richmond Va.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Beatrice Underwood
13. Birthplace Salisbury, Md.

MOTHER
14. Maiden Name Robert Lee Farrar
15. Birthplace Richmond, Va.

16 (a) Informant Mrs. Margaret Dennard
(b) Address 949 Bennett Place

17 (a) Burial (b) Date thereof Dec. 22-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Arbutus Mem.
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 3221 Edmondson Ave.

19 (a) DEC 22 1945 Huntington Williams, M.D.
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 20 1945, at 1:40 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:
(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Lateral Sinus (dural) Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Farrar M.D.
Medical Examiner.
Date signed 12-20-45

VS 151

G35446

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G35446

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 823 w mulberry St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Balt
(If outside city or town limits, write RURAL and give town)
(d) Street No. 823 w mulberry St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lewis Evans

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced.
mal	col	Married

6 (b) Name of husband or wife Fannie Evans
6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) July 26 1895

8. AGE: Years	Months	Days	If less than one day
50	4	24	hr. min.

9. Birthplace Cambridge, md
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Ned Evans
13. Birthplace md

MOTHER
14. Maiden Name Eliz Evans
15. Birthplace md

16 (a) Informant Emma Stevens
(b) Address 823 W. Mulberry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof d. 12-22-45 (month) (day) (year)
(c) Cemetery or crematory Int. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 Filed DEC 22 1945 (b) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-19 1945, at 9:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1945, to Dec 19 1945, and that I last saw him alive on Dec 19 1945.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Hypertension Cardio-vascular Renal Disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature H Eichhorn M. D.
Address 803 w Fremont Date signed

G35447 BALTIMORE CITY HEALTH DEPARTMENT G35447
CERTIFICATE OF DEATH
Registered No. 85

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2123 Pennsylvania Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2123 Pennsylvania Ave (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Sidney Rosenstein

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1924

8. AGE: Years	Months	Days	If less than one day
21			hr. min.

9. Birthplace Balto Md. (Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business

FATHER
12. Name Meyer
13. Birthplace Russia

MOTHER
14. Maiden Name Fannie
15. Birthplace Russia

16 (a) Informant Meyer
(b) Address Russia

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-23-45 (month) (day) (year)
(c) Cemetery or crematory Windsor Mill Rd
Location Windsor Mill Rd.

18 (a) Funeral director Jas C Lewis Sons
(b) Address 1439 E. Balto St

19 (a) DEC 29 1945 (Date received by registrar) Wellington Williams M.D. Registrar

VS 6

MEDICAL CERTIFICATION

20. DATE OF DEATH 21 Dec 1945, at 7:30 P.M.

21. I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained by said Inquiry find that said deceased came to his death on the day stated above.

Immediate cause of death	Duration
Epilepsy	13 yrs.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations —
Of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William J Helmich M.D. Medical Examiner.
Date signed 22 Dec 45

G35448

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G35448 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1629 Gwynns Falls Pkwy
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 57 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1629 Gwynns Falls Pkwy
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ABRAHAM SWITHGALL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex MALE | 5. Color or race WHITE | 6 (a) Single, married, widowed, or divorced WIDOW

6 (b) Name of husband or wife FANNIE

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1861

8. AGE: Years 84 | Months | Days | If less than one day ....hr. ....min.

9. Birthplace RUSSIA
(Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER
12. Name Hyman
13. Birthplace Russia

MOTHER
14. Maiden Name Lena
15. Birthplace Russia

16 (a) Informant Ethel Lurtsgall
(b) Address 1629 Gwynns Falls Pkwy

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-27-45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Mem Pk
Location Woodlawn Mem Pk

18 (a) Funeral director Jacob Lewis Inc
(b) Address 1434 E. Balto St

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 21 1945, at 7.15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 14 1945 to Dec 21 1945, and that I last saw h[illegible] alive on Dec 20 1945

Immediate cause of death Coronary Thrombosis — Duration 1 day

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Manuel Levin M. D.
Address 4818 Reisterstown Rd Date signed Dec 22/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35449

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G35449 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Use no abbreviations. Do not write above or below lines. Be sure that correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Ashburton Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 610 N. Monroe St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME LULA MOORE

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife: James Moore
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1, 1873

8. AGE: Years	Months	Days	If less than one day
72	8	20	hr. min.

9. Birthplace North Carolina (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Josh. Bell
13. Birthplace N. C.

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs. Maury A. Koonce
(b) Address 610 N. Monroe St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 12/22/45 (month) (day) (year)
(c) Cemetery or crematory Scotland Neck, N. C.
Location

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

1945 (Date rec'd by Registrar) Hector Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 21, 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1944 to Dec 21 1945; and that I last saw h alive on 19.

Immediate cause of death	Duration
Cerebral hemorrhage	
Due to Hypertension	
Due to arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Bernard Cohen M. D.
Address Marlboro Date signed 12/27/45

VS 150

G35450 ✓ G35450

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & 33rd St
(c) Hospital or institution:
Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 29 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto. City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 9 Englewood Rd - Roland Pk
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Evelin W Reed

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	Wh	Married

6 (b) Name of husband or wife James S Reed
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 20 - 18 99

8. AGE: Years	Months	Days	If less than one day
68	1	2.	hr. min.

9. Birthplace North Carolina
(Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name Same Willis
13. Birthplace South Carolina

MOTHER
14. Maiden Name ? Wallace
15. Birthplace North Carolina

16 (a) Informant James S. Reed
(b) Address 9 Englewood Rd Balto

17 (a) Removal (b) Date thereof 12/23/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location New Bern N.C.

18 (a) Funeral director William J. Ficken & Sons
(b) Address North Cor Ave

19 (a) DEC 23 1945 (b)
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec - 22 - 1945, at 10 25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec - 22 - 1945, to Dec - 22 - 1945, and that I last saw h EW alive on Dec - 22 - 1945.

Immediate cause of death Pneumonia — Duration

Due to

Due to

Other Conditions Arteriosclerosis C.V. Dis Cardiac Decompensation

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George F. Schlesinger M.D.
Address Union Memorial Date signed 12/24/45

VS 150

G35451 ✓ G35451

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Ave.
(c) Hospital or institution: St. Agnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 332 So. Smallwood St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Mary Watkins

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1861

8. AGE: Years 84 | Months | Days | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Isaac Profley
13. Birthplace Md.

MOTHER
14. Maiden Name Virgt
15. Birthplace Md.

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 26/1945 (month) (day) (year)
(c) Cemetery or crematory Montgomery
Location Clarksville Md

18 (a) Funeral director Roy W Barber
(b) Address Catonsville Md

19 (a) 1945 (Date rec'd by registrar) (b) Registrar

Hunter for Williams, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/22 1945, at 1P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/12 1945 to 12/22 1945, and that I last saw h.e.r alive on 12/22 1945

Immediate cause of death	Duration
Cardiac Failure	
Due to Hypostatic Pneumonia	
Due to	
Other Conditions Fracture Left Femur	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence Dec 12, 1945 M
(c) Where did injury occur? Balto, Md
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Slipped fell to floor

23. Signature R. Slee, M.D.
Address St Agnes Hosp Date signed 12/27/45 M.D.

Howard J. Meredith, M.D.

G35452

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

G35452 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2928 E. Fayette St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2928 E. Fayette St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Madeline Flickenschildt

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 2 - 1877

8. AGE: Years 68 | Months 1 | Days 19 | If less than one day ... hr. ... min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Home

11. Industry or business "

FATHER 12. Name Henry N. Flickenschildt
13. Birthplace Germany

MOTHER 14. Maiden Name Clementine Johanna
15. Birthplace Germany

16 (a) Informant Flickenschildt
(b) Address 2928 E. Fayette St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 24 45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Baltimore

18 (a) Funeral director Philip Hering Sons
(b) Address 2324 Eutaw St.

12 28 1945 (b) Herrington for William Griffith
(Date received by registrar) (Signature of registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 21 45 19 at 5:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1944 to 12-21 1945 and that I last saw h[illegible] alive on Dec 21 1945

Immediate cause of death ARTERIOSCLEROSIS — Duration 6 YRS

Due to CHR. INT. NEPH — 1 YR

Due to

Other Conditions CARCINOMA - LEFT THIGH. (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James F Kavanagh M.D.
Address 3328 McElderry Date signed 12-22-45

131a

G35453

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G35453 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 513 North Longwood Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days) 35 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 513 North Longwood Street (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME PEARL E. HARMON

3 (b) If veteran, name war ---

3 (c) Social Security Account No. 215-10-7530

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 20, 1877

8. AGE: Years 68 | Months 3 | Days 2 | If less than one day hr. min.

9. Birthplace Woodberry Ohio (Town, county, and state)

10. Usual Occupation Seamstress

11. Industry or business

FATHER
12. Name George Harmon
13. Birthplace Germany

MOTHER
14. Maiden Name Louise Coligrath
15. Birthplace Md.

16 (a) Informant Harmon H. Harris
(b) Address 513 N. Longwood St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 24, 1945 (month) (day) (year)
(c) Cemetery or crematory Middletown
Location Middletown Md.

18 (a) Funeral director Robt S. Slade
(b) Address 2700 Edmondson Ave

19 (a) 23 1945 (b)
(Date rec'd by registrar) Livingston Williams, Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/22/45 19 at 12:05 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to L.D.D. death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Ward M.D. Medical Examiner.
Date signed 12/22/45

G35454 BALTIMORE CITY HEALTH DEPARTMENT G35454
CERTIFICATE OF DEATH 61 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3.Chapel-Gate Lane
(c) Hospital or institution:
Ventnor Lodge Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 Mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 70 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ####
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 449 E.25th. St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ella M.McNamara

3 (b) If veteran, name war ---
3 (c) Social Security Account No. none

4. Sex Female | 5. Color or race Wht. | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Harry McNamara
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 8,1865

8. AGE: Years 80 | Months 3 | Days 13 | If less than one day ____ hr. ____ min.

9. Birthplace Harpers Ferry W.Va.
(Town, county, and state)

10. Usual Occupation House-wife

11. Industry or business

FATHER
12. Name John D.Potterfield
13. Birthplace W.Va.

MOTHER
14. Maiden Name Sarah Jenkins
15. Birthplace W.Va.

16 (a) Informant Walter C.Potterfield
(b) Address 329 Whitridge Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec.24,1945 (month) (day) (year)
(c) Cemetery or crematory Mt.Olivet
Location Balto. Md.

18 (a) Funeral director Robert S.Little
(b) Address 2700 Edmondson Ave.

19 (a) Dec 23 1945 (Date filed by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 21 1945, at 10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1945 to 12/21 1945 and that I last saw h[illegible] alive on 12/21/45 19

Immediate cause of death Coronary Occlusion 1 Hr.

Due to Arteriosclerosis

Due to

Other Conditions Diabetes Mellitus 2 Yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. Falagrid M. D.
Address 332 Whitridge Ave. Date signed 12/24/45

Registered by Virginia Williams, M.D. Registrar

VS 150

94a

G35455

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G35455 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1019 S. Kenwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2834 Elliott St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Stella Roth

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Andrew J.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1908

8. AGE: Years 37 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Michael Banaszak

13. Birthplace Poland

MOTHER 14. Maiden Name Cichon

15. Birthplace Poland

16 (a) Informant Andrew J. Roth

(b) Address 2834 Elliott St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/26/45 (month) (day) (year)

(c) Cemetery or crematory Holy Rosary Cem

Location Germantown Hill Rd

18 (a) Funeral director John J. Duda

(b) Address 2829 Hudson St.

19 (a) 1945 (Filed by registrar) Huntington Williams, M.D. Registrar

23 12 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/21 1945, at 7:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/19 1945, to 12/21 1945, and that I last saw her alive on 12/21 1945.

Immediate cause of death: Coronary occlusion — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Theodore T. Kwortowski M. D.

Address 1076 S. East Ave Date signed

VS 130

X 12/22/45

G35456

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G35456 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1212 N. Potomac St
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1212 N. Potomac St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dora L. Crowe

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: William Henry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 30 1865

8. AGE: Years 80 | Months 5 | Days 21 | If less than one day hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs Frank Vana
(b) Address 1212 N Potomac St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/24/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd

18 (a) Funeral director John F. Duda
(b) Address 2629 Hudson St

19 (a) 1945 (b) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 21 1945, at 11 40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 12 1939 to Dec. 21 1945 and that I last saw h[illegible] alive on Dec 21 1945

	Duration
Immediate cause of death: Coronary Thrombosis	6 days
Due to: Coronary Sclerosis	?
Due to: General Arterio-sclerosis	?
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Vincent F. Jokaitis M. D.
Address 845 N. Patterson Pk. Date signed 12/22/45

Date rec'd by registrar

VS 150

G35457

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 463

G35457 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1800 N. Washington St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits write RURAL and give town)
(d) Street No. 1800 N. Washington St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Herman Dorsch

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of ~~husband~~ or wife Mary Madkofski

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 11, 1869

8. AGE: Years 75 | Months 11 | Days 29 | If less than one day hr. min.

9. Birthplace Austria
(Town, county, and state)

10. Usual Occupation Brick Layer (Retired)

11. Industry or business

FATHER 12. Name Not Known
13. Birthplace Austria

MOTHER 14. Maiden Name Not Known
15. Birthplace Austria

16 (a) Informant Leo Dorsch
(b) Address 1800 N. Washington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/24/45 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Balto

18 (a) Funeral director C. J. Tamburini & Son
(b) Address 1938 E. Lafayette Ave.

19 1945 DEC 23 (b) Rec'd by registrar Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 21st 1945, at 10a M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 24 1945 to Dec 21 1945, and that I last saw him alive on Dec 20 1945

Immediate cause of death: Carcinoma of Stomach and Intestines — Duration 1½ years

Due to: Cachexia and Inanition — Duration 1 Month

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert Rosenberg
Address 2025 E. North Ave. Date signed 12/22/45
M. D.

G35458

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 131a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3047 Matthew Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CARRIE CRAVEN

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife George T.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1, 1872

8. AGE: Years	Months	Days	If less than one day
73	5	20	hr. min.

9. Birthplace Alexander, Virginia
(Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name John Schafe
13. Birthplace Virginia

MOTHER
14. Maiden Name Carrie
15. Birthplace Virginia

16 (a) Informant Mr. Ernest Craven
(b) Address 3047 Matthew Street

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 12/24/45 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Parkville, Maryland

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) 23 1945 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 21 1945, at 9:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 18 1945 to Dec 21 1945, and that I last saw h[illegible] alive on Dec 20 1945.

Immediate cause of death Pulmonary Edema — Duration Dec 17 1945

Due to Auricular fibrillation — 7

Due to Arterio-sclerotic cardio-vascular renal disease — years.

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Anthony J Thomas M. D.
Address 4600 York Rd Date signed 12-21-45

Registered by Eva Williams, M.D. Registrar

G35459 — N. Ogden 2701 W Calvert St

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. G35459

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 406 E. 27th St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

12

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 406 E 27th St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lillie Lavinia Orem

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Walter W
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): Nov 6 1876
8. AGE: Years 69 | Months 1 | Days 6 | If less than one day hr. min.
9. Birthplace: Maryland (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business:
FATHER 12. Name: Luke Hartzell
13. Birthplace: Unknown
MOTHER 14. Maiden Name: Anna Graham
15. Birthplace: Unknown
16 (a) Informant: Walter W Orem
(b) Address: 406 E 27th St
17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 12/24/45 (month) (day) (year)
(c) Cemetery or crematory: Woodlawn
Location: Woodlawn Md
18 (a) Funeral director: Wilson Funeral Home
(b) Address: 1217 E Fort Ave
19 (a) 12 28 1945 (Date rec'd by registrar) (b) Herrington for Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 22 1945, at 5 15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 22, 1945, to Dec. 22, 1945, and that I last saw him alive on Dec. 22, 1945

Immediate cause of death	Duration
Coronary Occlusion	immediate
Due to Hypertension & Arteriosclerosis	2 years
Due to Diabetes	2 years
Other Conditions ✓	

(Include pregnancy within 3 months of death)
Date of operation ✓
Major findings of operation: ✓
of autopsy ✓

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ✓
(b) Date of occurrence ✓ at ✓ M
(c) Where did injury occur? ✓ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Frank M. Ogden M. D.
Address 2701 W. Calvert St Date signed Dec. 22 45

VS 150

X

G35460

BALTIMORE CITY HEALTH DEPARTMENT

CWK-97718

CERTIFICATE OF DEATH 1945

G35460

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The age is especially important. Physicians: please complete the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Avenue

(c) Hospital or institution: Baltimore City Hospitals 41

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 Days

(e) Length of stay in Baltimore (yrs., mos., or days) 29 Yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 15 N. Pearl Street
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Matthew Ussery

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Cora Kelley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1-1885

8. AGE: Years	Months	Days	If less than one day
60	7	20	hr. min.

9. Birthplace North Carolina
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Robert M. Ussery
13. Birthplace North Carolina

MOTHER
14. Maiden Name Annie Owens
15. Birthplace North Carolina

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/26/45
(month) (day) (year)

(c) Cemetery or crematory Mt Olivet
Location Baltimore Md

18 (a) Funeral director Tilhorn & Son Inc
(b) Address 1217 E Fayette St

19 (a) DEC 29 1945 (b) Livingston Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 21 1945, at 5:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 6 1945, to Dec. 21 1945, and that I last saw h. im alive on Dec. 21 1945.

Immediate cause of death	Duration
Cardiac Failure	
Due to Hypertensive Cardiovascular Disease	
Due to	
Other Conditions	
(Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation: None

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature T. P. Gerrigan

Address Baltimore City Hall Date signed 12-27-45
M. D.

Every item of information should be carefully supplied. Use write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Ev correct age is especially important. Physicians: please write

G35461 Collignon BALTIMORE CITY HEALTH DEPARTMENT G35461

CERTIFICATE OF DEATH √ 195E

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1276 Clifton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Lewis Collignon

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Amelia
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 12 1884

8. AGE: Years	Months	Days	If less than one day
61	4	10	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation Cigar Maker Retired
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Frederick Gilkerson
(b) Address 52 Dunkirk Rd Roland Park

17 (a) Burial (b) Date thereof 12/26/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Ft Matthew
Location Baltimore Md

18 (a) Funeral director Wilhem Bros Inc
(b) Address 1214 E Fort Ave

19 (a) (b)
(Date rec'd by registrar) Huntington Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 22 1945, at 6 35 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
(Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Ruptured Gastric ulcer; Generalized peritonitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☑ cause of death, fill in the following:
(a) Date of injury Dec. 22 1945 11/1 2 P.M.
(b) Where did injury occur? at Post Office at Nat Royal & St Paul Sts
(c) Did injury occur at home, on farm, industrial place, in public place? Post Office While at work? yes
(d) Means of injury struck in abdomen by mail conveyor

23. Signature Roland Lee Gratton M.D.
Medical Examiner.
Date signed 12-22-45

G35462

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 33B

G35462 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 608 Harrod Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 608 Harrod Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma A Owens

3 (b) If veteran, name war: W
3 (c) Social Security Account No. none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Horace R Owens
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) March 20 1886
8. AGE: Years 85 | Months 8 | Days 21 | If less than one day hr. 60 min.
9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Isaac Wright
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Wolfe
15. Birthplace Maryland

16 (a) Informant Sister Maryland
(b) Address 718 Arlington Ave Towson
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/24/45 (month) (day) (year)
(c) Cemetery or crematory Union Bridge
Location Union Bridge Md
18 (a) Funeral director Tillson Funeral Home
(b) Address 127 E Pratt St
19 (a) (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 21 1945 at 9 10 M
21. I certify that death occurred on the date above stated; that I attended deceased from Dec 20 1945 to Dec 21 1945 and that I last saw h alive on Dec 20 1945.

Immediate cause of death: Influenza — Duration: 2 days
Due to:
Due to:
Other Conditions: Bronchitis
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature H. H. Deane M. D.
Address 2105 N Charles Date signed Dec 24/45

Huntington Hill Registrar

VS 150

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35463

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

81a

Registered No. G35463

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 629 W Lafayette Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Judith Bunny.

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-10-45

8. AGE: Years	Months	Days	If less than one day
	7.	11	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Bunny.
13. Birthplace W. Va

MOTHER
14. Maiden Name Ruby Buckhannon
15. Birthplace W. Va

16 (a) Informant Friends
(b) Address [illegible]

17 (a) Burial (b) Date thereof Dec. 24/45
(Burial, cremation, or removal) (month), (day), (year)

(c) Cemetery or crematory Mount Olivet
Location Frederick Ave., Balto.

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 1306 Eutaw Place

19 (a) [illegible] (b)
(By whom filed) (Date filed) Registrar

23 1945

VS 190

Huntington for Williams, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 21 1945 at 9.40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 21 1945 to Dec. 21 1945 and that I last saw h.m. alive on Dec. 21 - 1945.

Immediate cause of death Pneumococcal meningitis — Duration 12 hrs

Due to

Due to

Other Conditions Malnutrition

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harrison Clark Spencer M. D.
Address Johns Hopkins Hospital Date signed 12-22-45

X

G35464

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

G35464

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 204 E. Highfield Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Franklin Jones Sherwood

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: single
6 (b) Name of husband or wife: John W. Sherwood
6 (c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) Mch 27, 1871

8. AGE: Years 74 | Months 8 | Days 24 | If less than one day ____ hr. ____ min.

9. Birthplace Balto.
(Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER
12. Name Thos. Jones
13. Birthplace Balto.

MOTHER
14. Maiden Name Mary E. Thomas
15. Birthplace Balto.

16 (a) Informant John R. Sherwood
(b) Address 722 Taplow Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 24, 1945 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville Balto Co.

18 (a) Funeral director John O. Mitchell Home
(b) Address 1900 Eutaw Place

19 (a) (Date received by registrar) (b) Huntington Williams, M.D. Registrar

DEC 28 1945

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 21 1945, at 4:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/2 1945, to 12/21 1945, and that I last saw h-- alive on 12/21 1945.

Immediate cause of death: Coronary Occlusion

	Duration
Due to: C.B. Head of Pancreas with	
Due to: glan. metastases	
Other Conditions: Jaundice & Bleeding Gut.	

(Include pregnancy within 3 months of death)

Date of operation 12/11/1945

Major findings of operation: Ca Head of Pancreas with early metastases

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. A. Cowley M.D.

Address Univ. Hospt. Balto. Date signed Dec 24 1945 M. D.

G35465

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G35465 Registered No.

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 265 Colvin St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 265 Colvin St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maurice B. Nichols

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb. 1886

8. AGE: Years 59 | Months 2 | Days | If less than one day ___ hr. ___ min.

9. Birthplace Keswick Va.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Charlie Nichols.
13. Birthplace Va

MOTHER 14. Maiden Name Jane Nicholson
15. Birthplace Va

16 (a) Informant Marie Head
(b) Address 308 W. Biddle St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-24-45 (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location Balto Md.

18 (a) Funeral director Byron T. Mannix & Son
(b) Address 727 Eutaw St

19 (a) 12-23-1945 (Date rec'd by registrar) (Signature of Registrar) Thurlington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 19 1945, at 4 or T M

21. I certify that death occurred on the date above stated; that I attended deceased from May '44 19 to Dec. 19 1945. and that I last saw him alive on Dec. 19 1945

Immediate cause of death Cerebral Hemorrhage — Duration
Due to Pulmonary edema
Due to
Other Conditions Chr. alcoholism
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Morris A. Frye M. D.
Address 118 E. Fayette St Date signed 12/23/45

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35466

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G35466

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 621 S. CONKLING ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 9
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County BALTO.
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 621 S. CONKLING ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME GERTRUDE ELBERTH

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	SINGLE

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DEC. 31 1884

8. AGE: Years	Months	Days	If less than one day
60 61	11	19	hr. min.

9. Birthplace BALTIMORE MD. (Town, county, and state)
10. Usual Occupation HOUSE WORK
11. Industry or business AT HOME

FATHER
12. Name AUGUST ELBERTH
13. Birthplace GERMANY

MOTHER
14. Maiden Name ANNIE RITGERT
15. Birthplace GERMANY

16 (a) Informant JOHN W. ELBERTH (BROTHER)
(b) Address 621 S. CONKLING ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof DEC. 24/45 (month) (day) (year)
(c) Cemetery or crematory SACRED HEART
Location GERMAN HILL ROAD

18 (a) Funeral director Leilly & Zeiler inc.
(b) Address 403 S. WOLFE ST.

23 1945 (Date rec'd by registrar) Huntington Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH DEC. 19 1945, at 9 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1930 to Dec 18 1945 and that I last saw h[illegible] alive on Dec 18 1945.

Immediate cause of death Carcinoma of Colon — Duration 3 mo

Due to

Due to

Other Conditions Multiple Metastases Adenocarcinoma Hypertension & Cardiac 3 14 46
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph Zeiler M. D.
Address 1701 E Fayette St Date signed 12/22/45

VS 180

G35467 BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Hills Sgt. - Seymour Johnson Field

G35467 Registered No. 94a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County BALTO.
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. ? (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Howard L. Manahan

3 (b) If veteran, name war: 2 W.W.

3 (c) Social Security Account No.: ?

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: ?

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): ?

8. AGE: Years 45 | Months | Days | If less than one day hr. min.

9. Birthplace ? (Town, county, and state)

10. Usual Occupation SOLDIER

11. Industry or business US. ARMY

FATHER 12. Name ?

13. Birthplace ?

MOTHER 14. Maiden Name ?

15. Birthplace ?

16 (a) Informant ARMY RECDS

(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof DEC. 26/45 (month) (day) (year)

(c) Cemetery or crematory FOXVILLE CEM.

Location FOXVILLE MD.

18 (a) Funeral director Lilly & Zeiler Inc.

(b) Address 403 S. WOLFE ST.

19 (a) (b) Registrar

(Date received by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 21, 1945 at 1 30 A.M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Howard J. Walker M.D. Medical Examiner.

Date signed 12-22-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35468

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G35468 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St. City
(c) Hospital or institution:
Sisters Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Divney Roderick
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	widowed

6 (b) Name of husband or wife Marion Roderick
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 29, 1863

8. AGE: Years	Months	Days	If less than one day
82 yrs	4 5	2 3	hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation domestic
11. Industry or business

FATHER
12. Name John Divney
13. Birthplace Ireland

MOTHER
14. Maiden Name Bridget Crogan
15. Birthplace Ireland

16 (a) Informant Sister Sisters of the Poor
(b) Address 1200 Valley St City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 24 1945 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 917 Greenmount Ave

19 (a) Dec 29 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 21 1945, at 1140 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1945, to Dec 21 1943, and that I last saw h[illegible] alive on Dec 20 1945

Immediate cause of death	Duration
Edema Lungs	1 day
Due to Chronic Myocarditis	2 yrs
Due to	
Other Conditions Arteri Sclerosis	5 yrs

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E Bell Hall M. D.
Address 1631 E North av Date signed Dec 22-45

VS 150

G35469

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

G35469 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 343 S. Bentalou Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) 41 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 343 S. Bentalou Street (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mabel A. Dimler

3 (b) If veteran, name war None
3 (c) Social Security Account No. None

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Joseph Dimler
6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) November 23, 1896

8. AGE: Years	Months	Days	If less than one day
49		28	hr. min.

9. Birthplace Cambridge, Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John E. Adams
13. Birthplace Maryland

MOTHER
14. Maiden Name Abbie F. Creamer
15. Birthplace Maryland

16 (a) Informant Joseph Dimler
(b) Address 343 S. Bentalou Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-24-45 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore, Maryland

18 (a) Funeral director Lloyd L. Gelwicks
(b) Address 2101 Frederick Avenue

1945 Date rec'd by registrar Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 21, 1945, at 11:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/1 1945 to 12/21/45 1945, and that I last saw her alive on 12/21/45 1945.

Immediate cause of death Carcinoma of cervix — Duration 6 mos.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 4/10/45

Major findings of operation: Carcinoma of cervix

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Benjamin Miller M. D.
Address 2070 Wilkens Ave Date signed 12/24/45

G35470

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G35470 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene sts.
(c) Hospital or institution: University Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 18 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1817 W. Milton Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Dora Reed — Dora Elizabeth Reed

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife Divorced
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 6, 1913

8. AGE: Years	Months	Days	If less than one day
32	1	15	hr. min.

9. Birthplace Marriottsville, Howard County, Md. (Town, county, and state)
10. Usual Occupation Making fronts on distillery
11. Industry or business National Distillery

FATHER
12. Name Harvey S. Reed
13. Birthplace Maryland

MOTHER
14. Maiden Name Emma M. Bell
15. Birthplace Maryland

16 (a) Informant Mrs. Audrey Wallo
(b) Address 1601 Montford Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-24-45 (month) (day) (year)
(c) Cemetery or crematory Howard Chapel
Location Howard Chapel Md.

18 (a) Funeral director George L. Schwab
(b) Address 2101 Frederick Avenue

19 (a) DEC 3 1945 (Date rec'd by registrar) (b) Huntington Williams, Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-21 1945 at 5:40 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-20 1945 to 12-21 1945 and that I last saw her alive on 12-21 1945

Immediate cause of death	Duration
Respiratory Failure.	
Due to (a) Toxic abortion	
from gasbacillary bilateral pneumonia	
Due to (b) Complicated with	
carcinoma adenoma.	
Other Conditions Leukopenia severe	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations:
of autopsy Under Committee's Confirmed

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Douglas E. Bradshaw M.D. M. D.
Address University Hosp. Date signed 12-21-45

G35471

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

G35471 Registered No.

Every item of information should be carefully supplied. Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1/2 mo.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1516 Harlem Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: Hattie Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 9, 1907

8. AGE: Years 38 | Months 8 | Days 9 | If less than one day hr. min.

9. Birthplace Gloucester Co. Va. (Town, county, and state)

10. Usual Occupation Teacher

11. Industry or business Public school

FATHER
12. Name Sterling Smith
13. Birthplace Gloucester Co Va

MOTHER
14. Maiden Name Sidney Jones
15. Birthplace Gloucester Co Va.

16 (a) Informant Sidney Roulette
(b) Address 1516 Harlem Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 23, 1945 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem Pk.
Location Baltimore Co. Md.

18 (a) Funeral director Wm. Syd. A. Hall
(b) Address 1631 Druid Hill Ave

19 (a) DEC 23 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 18, 1945 at 3 A. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, or undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Gunshot wounds of chest
Gunshot wound of thigh
due to

Other Conditions Hemothorax

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-17-45 11:30 P. M.
(b) Where did injury occur? 1516 Harlem Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Shooting

23. Signature Benedict Skotarchi M.D. Medical Examiner.
Date signed 12-18-45

VS 151

G35472

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1108

G35472
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1132 Dolphin St
(c) Hospital or institution: Balto, Md

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1132 Dolphin
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Cordee

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Fem

5. Color or race Col

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife William Cordee

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1899

8. AGE: Years 46 | Months | Days | If less than one day hr. min.

9. Birthplace Cutzetersville Md
(Town, county and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant William Cordee
(b) Address 1132 Dolphin St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 23, 1945 (month) (day) (year)

(c) Cemetery or crematory Arbutus Mem. Pk
Location Baltimore Co. Md.

18 (a) Funeral director Wm. Geo. H. Holland
(b) Address 631 Druid Hill Ave

19 (a) Date received by registrar DEC 23 1945 (b) Huntington for Williams MHO

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/20/45, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/19/45 to 12/20/45, and that I last saw h alive on 12/19/45

Immediate cause of death Duration

Due to Lobar Pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hackleman M.D.

Address 1131 Hals Harlem Ave Date signed

G35473

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

CEK-96340

G35473
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2- 25
(e) Length of stay in Baltimore (yrs., mos., or days) 5 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 514 Willow Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Laura Cook

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 5-1868

8. AGE: Years	Months	Days	If less than one day
77	3	18	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Hubbard
13. Birthplace Maryland

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 26/45 (month) (day) (year)
(c) Cemetery Steddon
Location Cambridge, Md

18 (a) Funeral Director O. Mitchell & Son
(b) Address 1901 Eastern Ave.

Registrar

Dec 24 1945
VS Rec'd
Thurlington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH December 23 1945, at 3 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 28 1945 to Dec. 25 1945, and that I last saw h. alive on Dec. 23 1945.

Immediate cause of death	Duration
a Bronchopneumonia	7
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: none
of autopsy none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature T. P. Jernegor M. D.
Address Baltimore City Hosp. Date signed 12-27-45

X

G35474

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

G35474 Registered No.

Every item of information should be carefully written. Please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1908 W. Lexington St.
Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1908 W. Lexington St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WALTER J. CASSIDY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife late Mary C.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 21, 1879

8. AGE: Years	Months	Days	If less than one day
66	4	1	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Book Binder

11. Industry or business Retired

FATHER 12. Name James A. Cassidy
13. Birthplace Ireland

MOTHER 14. Maiden Name Sarah A. Brockard
15. Birthplace Baltimore Md.

16 (a) Informant Miss May Cassidy
(b) Address 810 E. Preston St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/24/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Cathedral
Location 4300 Old Frederick Road

18 (a) Funeral director John J. Cowan & Son
(b) Address 902-03 Hollins St.

DEC 24 1945 (Date received) Huntington Williams M.D. (Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 22, 1945 at 3:35 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Marked cardiac hypertrophy and dilatation

Due to Advanced coronary sclerosis

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Forster M.D.
Medical Examiner.
Date signed Dec. 23 1945

635-175

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 171a

Registered No. 635-175

Every item of information should be carefully checked. Be sure to write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days) 39 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3911 Fairview Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** SIMON SCHOCKET

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1899

8. AGE: Years 46 | Months | Days | If less than one day hr. min.

9. Birthplace: Russia
(Town, county, and state)

10. Usual Occupation: Furniture Business

11. Industry or business

FATHER
12. Name: Benjamin Schocket
13. Birthplace: Russia

MOTHER
14. Maiden Name: Toby Gertrude Schockett
15. Birthplace: Russia

16 (a) Informant: Miss Amelia Schocket
(b) Address: 3911 Fair View Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 24, '45 (month) (day) (year)
(c) Cemetery or crematory: Beth Tfiloh Cemetery
Location: Windsor Mill Road

18 (a) Funeral director: Sol Levinson & Bros
(b) Address: 1124-1126 W North Ave

DEC 24 1945 (Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 23, 19 45, at 1:30A. M

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractures of Skull
Compound comminuted
Fractures of Legs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-23-45 at 21-17 M.
(b) Where did injury occur? Park Heights Ave. In Vicinity of Oakley Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian struck by streetcar

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Dec. 23 1945-

635476

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

635476 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2308 Anoka
(c) Hospital or institution: 15

(d) Length of stay in hospital or inst. (yrs., mos., or days) one
(e) Length of stay in Baltimore (yrs., mos., or days) 39 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2308 Anoka ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Louis Furst

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Celia Furst
6 (c) If alive, give age 6 years

7. Birth date of deceased (mo., day, yr.) 1884 4 3 March

8. AGE: Years	Months	Days	If less than one day
61	9		hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Cattle Dealer
11. Industry or business

FATHER
12. Name Benjamin Furst
13. Birthplace Russia

MOTHER
14. Maiden Name Faga Brosin
15. Birthplace Russia

16 (a) Informant Wife Celia Furst
(b) Address 2308 Anoka

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 25/45 (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cem
Location Hamilton ave

18 (a) Funeral director Sol Levinson Bros
(b) Address 1124-26 W North ave

19 (a) DEC 24 1945 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 23 1945, at 7.05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1940 to Dec 23 1945 and that I last saw him alive on Dec 1945

Immediate cause of death Cerebral arteriosclerosis — Duration 5 yr

Due to

Due to

Other Conditions Terminal Pneumonia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Milton B. Kress M. D.
Address 2311 Cadwalader Date signed Dec 23 1945

(OVER)

VS 150

G35-177 ✓ G35-177

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 1 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltemore (If outside city or town limits, write RURAL and give town)
(d) Street No. 217 Prendent st (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John F. Jankiewicz

3 (b) If veteran, name war

3 (c) Social Security Account No. 211-02-4833

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of wife Frances

6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) Nov. 15, 1893

8. AGE: Years	Months	Days	If less than one day
52	1	7	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business Abrams & Son Clothing Mfg.

FATHER
12. Name Adam Jankiewicz
13. Birthplace Ansedon

MOTHER
14. Maiden Name Jankeson
15. Birthplace Jankenson

16 (a) Informant Mrs. Frances Jankiewicz (wife)
(b) Address 2241 McElderry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-24-45 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Baltimore, Md

18 (a) Funeral director Leazy A Weber
(b) Address 705 S. Ann st

19 (a) DEC 21 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 22 1945, at 5:30 A.M.

21. I certify that I took charge of the remains described above, held an Partial Aut Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Depressed Fracture of Skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-21-45 at 9:50 P.M.
(b) Where did injury occur? 217 Prendent st
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work?
(d) Means of injury Fell down steps

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 12-22-45

VS 151

G35178

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 82a

Registered No. G35178

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 807 W. Lafayette ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16

(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 807 W. Lafayette ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elugah House

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colrd	Widowed

6 (b) Name of husband or wife Cynthia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1863

8. AGE: Years	Months	Days	If less than one day
82			hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Oyster Shucker

11. Industry or business

FATHER
12. Name unk
13. Birthplace unk

MOTHER
14. Maiden Name unk
15. Birthplace unk

16 (a) Informant Cynthia House

(b) Address 807 W. Lafayette ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 24-45 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location

18 (a) Funeral director James A Davis

(b) Address 142 W Pratt St. Balto

19 (a) DEC 24 1945 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 20 1945, at 7.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/20/45 to 19; and that I last saw h alive on 19.

Immediate cause of death	Duration
Cerebral	
Due to Hemorrhage	
Due to	
Other Conditions Hypertensive	1 month

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H Adelbowe M. D.

Address 1131 Harlem Date signed 12/21/45

VS 150

G35479

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G35479
Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens + Caton ave
(c) Hospital or institution:
St. Agnes Hospital 20
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2713 W Balto St
2713 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country —

3 (a) FULL NAME Charles F Knapp

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Anna Mary Knapp

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 7 - 1884

8. AGE: Years 61 | Months 7 | Days 14 | If less than one day hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation Retired (Restaurant)

11. Industry or business

FATHER
12. Name Herman Knapp.
13. Birthplace Md

MOTHER
14. Maiden Name Mary Rose Creamer
15. Birthplace Wash DC.

16 (a) Informant Mr Harry Bloden
(b) Address Riggs Ave

17 (a) Burial (b) Date thereof 12/24/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto Md

18 (a) Funeral director Geo. L Berger Jr
(b) Address 15 N Hollins St

19 (a) DEC 24 1945 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/21/ 1945 at 2 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/21/ 1945 to 12/21 1945.
and that I last saw him alive on 12/21 1945

Immediate cause of death acute cardiac failure

Due to Cerebrovascular C-V-D

Due to

Other Conditions Pernicious anemia, Diabetes

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Cliff Rafft Jr M. D.

Address 29 Upper Mosp Date signed 12/24/45

937

G35480 BALTIMORE CITY HEALTH DEPARTMENT ✓ G35480

CERTIFICATE OF DEATH 54a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Catons ave.
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Halethorpe (If outside city or town limits, write RURAL and give town)
(d) Street No. 4501 Ridge ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William G. Reisa

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Lillie Reisa

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 16-1874

8. AGE: Years 59 | Months 1 | Days 4 | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business Furniture

FATHER 12. Name Geo. W. Reisa

13. Birthplace Germany

MOTHER 14. Maiden Name Johanna Barthelbrener

15. Birthplace Md

16 (a) Informant Mrs. Lilly Reisa

(b) Address 4501 Ridge ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/24/45 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Balto Md

18 (a) Funeral director Geo Koenig & Co

(b) Address 15 N Howard St

19 (a) DEC 24 1945 (Date received by registrar) (b) Washington Wilson Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 20 1945 at 8:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/7/45 1945 to 12/20 1945, and that I last saw him alive on 12/20 1945

Immediate cause of death Tumor of brain - Glioma — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Tumor of brain - Glioma

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.

Address St Agnes Hosp Date signed 12/26/45

635181

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered No. 635181

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered. Be sure that the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: South Balto. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 2

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 527 S. Charles St (If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME Bradley [redacted] Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug. 24, 1942

8. AGE: Years: 3yrs | Months: 3 | Days: 28 | If less than one day ..... hr. ..... min.

9. Birthplace Ohio (Town, county, and state)

10. Usual Occupation mond

11. Industry or business

FATHER — 12. Name Charles Brown
13. Birthplace Kentucky

MOTHER — 14. Maiden Name Bessie Viers
15. Birthplace Kentucky

16 (a) Informant Mrs Bessie Brown
(b) Address 527 S. Charles St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/24/45 (month) (day) (year)
(c) Cemetery or crematory.....
Location Portsmouth, Ohio.

18 (a) Funeral director John F. Denny, Inc.
(b) Address 715 Light St.

19 (a) DEC 24 1945 (Date rec'd by registrar) (b) Huntington, W. Va. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/22 1945 at 11:25 P.M.

21. I certify that I took charge of the remains described above, held an Inquest-Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bronchopneumonia

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at ..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature P. J. Lubinski M.D. (Medical Examiner)
Date signed 12/23/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

#35482.-

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

#35482 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2709 Barclay St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State ..... (b) County .....
(c) City or town ..... (If outside city or town limits, write RURAL and give town)
(d) Street No. 2709 Barclay St (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Baby Saunders (premature) 6 mos.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
I F	W	—

6 (b) Name of husband or wife —

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec 22 1945

8. AGE: Years	Months	Days	If less than one day
+		1	..... hr. ..... min.

9. Birthplace above (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Winfield Saunders
13. Birthplace Va

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Faith
(b) Address above

17 (a) ..... (Burial, cremation, or removal) (b) Date thereof Dec 23 1945 (month) (day) (year)
(c) Cemetery or crematory Belair Rd
Location Holy Redeemer Con

18 (a) Funeral director Joseph Farace Inc
(b) Address 2013 Greenmount Ave

19 (a) ..... (b) .....

DEC 24 1945 Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 23 1945, at 9A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 22 1945 to Dec 23 1945, and that I last saw h..... alive on ..... 19 .....

Immediate cause of death	Duration
Premature	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? ..... (Specify type of place)
(e) Means of injury .....

23. Signature M. Eghan M. D.
Address 443 E 45th St Date signed 12-24-45

X

G35183 HANKS

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G35183 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1066 W Fayette
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 + 2
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 1066 W Fayette St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hettie Mary Hanks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife John W. Hanks

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1867

8. AGE: Years	Months	Days	If less than one day
78			hr. min.

9. Birthplace Crew Va (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER
12. Name unk
13. Birthplace

MOTHER
14. Maiden Name Henretta Durbin
15. Birthplace Crew Va

16 (a) Informant Hennetta Cobb
(b) Address 1066 W Fayette

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/24/45 (month) (day) (year)
(c) Cemetery or crematory
Location Crew, Va

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantley Ave

19 (a) DEC 24 1945 (Date rec'd by registrar) (b) Huntington Wilson

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-20-1945 at 6:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/4 1945, to 12-20 1945, and that I last saw h[illegible] alive on 12-18-1945

Immediate cause of death Chronic Cardio-vascular Renal Disease

Due to hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
10 yrs

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify kind of place) While at work?
(e) Means of injury

23. Signature [illegible]
Address Crew Burlington signed 12/27/45

G35484

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93c

Reg. Dist. No.

G35484

1. PLACE OF DEATH:

City or town: 2018 Brookfield Ave (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, institution, or street address where death occurred: 2018 Brookfield Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md. County Baltimore

City or town Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 51 East North Ave. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Edyth Mary Ridgeway

3.(b) Social Security Number

4. Sex: Female

5. Color or race: W

6.(a) Single, married, widowed, or divorced: married

6.(b) Name of husband or wife: Sherman H. Ridgeway

6.(c) If alive, give age: 52 years

7. Birth date of deceased (mo., day, yr.): 1893

8. AGE: Years: 47 | Months | Days | If less than one day: hrs. min.

9. Birthplace: Hagerstown, Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

12. Name: Lovina N. Towe

13. Birthplace: Hagerstown, Md.

14. Maiden name: Ethel M. Towe

15. Birthplace: Hagerstown, Md.

16. Informant: Herbert P. Ridgeway

Address: 2018 Brookfield Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/26/45 (month) (day) (year)

Cemetery or crematory: Rose Hill

Location: Hagerstown

18. Funeral director: H. K. Hoffman

Address: Hagerstown Md

19. DEC 24 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12/23/1945 at 5:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 10 1945 to 12/23 1945 and that I last saw h.. alive on 12/21/45

Immediate cause of death: Cardiac Failure — DURATION

Due to: Hypertensive Cardiovascular disease.

Due to: Senile Atrophy

Other conditions: Arthritis Deformans

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Murray Rigl M. D. or other

Address 29 E. Patrick St. Date signed 12/23/45

635485

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

635485 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 205 N. Lanvale
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11-4
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 205 W. Lanvale St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Alexander Stewart

3 (b) If veteran, name war	3 (c) Social Security Account No.
✓	✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Sarah B Carter
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) July 10 1870

8. AGE: Years	Months	Days	If less than one day
75	5	12	hr. min.

9. Birthplace Balto Md
(Town, county, and state)
10. Usual Occupation Lawyer
11. Industry or business

FATHER
12. Name Judge Wm A. Stewart
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Emily Slaughter
15. Birthplace Culpepper Va.

16 (a) Informant Mrs Wm A. Stewart
(b) Address 205 N. Lanvale St

17 (a) Burial (b) Date thereof Dec 24 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Balto. Md

18 (a) Funeral director Henry H. Jenkins Sons Co
(b) Address McCulloh-Orchard Sts

19 (a) Date received by Registrar DEC 24 1945 (b) Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 22 1945; at 1 P M
21. I certify that death occurred on the date above stated; that I attended deceased from 11/30 1945 to 12/22 1945 and that I last saw him alive on 12/22 1945.

Immediate cause of death	Duration
Cerebral Vascular Accident	23 days
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)
(e) Means of injury

23. Signature Francis W. Sluck M. D.
Address 715 Park ave Date signed 12/23/45

G35486 — BALTIMORE CITY HEALTH DEPARTMENT — G35486

CERTIFICATE OF DEATH

107 — Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution: U. University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Q. A.
(c) City or town Cedar Hill
(If outside city or town limits, write RURAL and give town)
(d) Street No. —
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country —

3 (a) **FULL NAME** Rufus Mc Clellan

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	N	M

6 (b) Name of husband or wife Emma —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — 1901

8. AGE: Years	Months	Days	If less than one day
44 4 2	—	—	— hr. — min.

9. Birthplace Penn.
(Town, county, and state)
10. Usual Occupation Gardener Laborer
11. Industry or business —

FATHER
12. Name John McClellan
13. Birthplace Penn

MOTHER
14. Maiden Name Wade
15. Birthplace Penn.

16 (a) Informant
(b) Address

17 (a) Burial (b) Date thereof Dec 24 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St

19 DEC 24 1945 (b) [illegible]
(Date rec'd by Registrar) Registrar

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/19 1945, at 7 25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/17 1945 to 12/19 1945, and that I last saw him alive on 12/19 1945.

Immediate cause of death Respiratory failure — Duration

Due to Bronchial pneumonia, bilateral

Due to —

Other Conditions Jaundice

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: Above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address [illegible] Hosp. Date signed 12/21/45 M. D.

X

G35187

484285

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

69

Registered No. G35487

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully written. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 503 W. Pennsdale St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Estia Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: Black. | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: William Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1901.

8. AGE: Years 44 | Months | Days | If less than one day hr. min.

9. Birthplace Queen Anne Co. Md. (Town, county, and state)

10. Usual Occupation Home. wife.

11. Industry or business

FATHER 12. Name William Buckrey

13. Birthplace Md.

MOTHER 14. Maiden Name Josephine Hamilton

15. Birthplace Md.

16 (a) Informant Rennda.

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 24 1945 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cem

Location

18 (a) Funeral director Mrs Katie R. Williams

(b) Address 922 N. Schroeder St.

19 (a) (Date received by registrar) (b) Registrar

DEC 24 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 19 1945, at 10.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 26 1945, to Dec 19 1945, and that I last saw h.. alive on Dec. 19 1945.

Immediate cause of death	Duration
? Pulmonary embolism	
? Pellagra	
Due to: ? Pernicious Anemia	
Due to Diarrhea	
Other Conditions Macrocytic Anemia	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William D. Dixon

Address Johns Hopkins Hospital Date signed 12/28/45

X

G35188

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1312

Registered No. G35188

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered. Write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1224 Argyle Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1224 Argyle Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leroy Pinn
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Widower

6 (b) Name of husband or wife Cassie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 2, 1868

8. AGE: Years	Months	Days	If less than one day
77	2	19	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Jermiah Pinn
13. Birthplace Md

MOTHER
14. Maiden Name Matilda Wiggins
15. Birthplace Va.

16 (a) Informant Eunice Wood
(b) Address 1224 Argyle Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 24, 1945 (month) (day) (year)
(c) Cemetery or crematory Mt Zion Cem.
Location
18 (a) Funeral director Mrs. Robert A. Elliott Dept
(b) Address 129 N. Caroline St.
19 (a) DEC 24 1945 (Date rec'd by registrar) Huntington Hill (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/21/1945 at 1 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1945 to Dec 21 1945, and that I last saw him alive on Dec 20 1945.

Immediate cause of death Mitral Insufficiency and Degenerative Myocarditis — Duration Probably Complications

Due to

Due to

Other Conditions Chronic Nephritis and Chronic Pulmonitis
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ralph J. Young, M.D.
Address 1424 E. Monument St. Date signed 12/24/45

G35489 37423

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95B

G35489 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-4
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 911 Rutland Ave
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Ben Downtin

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Married

6 (b) Name of husband or wife Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1919

8. AGE: Years	Months	Days	If less than one day
26			.....hr. .....min.

9. Birthplace N. Carolina (town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Bennie Downtin
13. Birthplace N. Carolina

MOTHER
14. Maiden Name.....
15. Birthplace

16 (a) Informant Records JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Removal (b) Date thereof Dec 24/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory.....
Location Richmond Va.

18 (a) Funeral director Mrs. Estes G. Elliott Dft.
(b) Address 1129 E. Baltimore St

19 (a) DEC 24 1945 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 22 1945 at 7 C M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 20 1945 to Dec 22 1945
and that I last saw him alive on Dec 22 1945

Immediate cause of death	Duration
(a) Pulmonary Embolism	
Due to Rheumatic Heart	
Due to disease with congestive failure	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operation:.....
.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence.....at.....M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?.....While at work?.....
(Specify type of place)
(e) Means of injury.....
23. Signature Graham G. Peirce
Address Johns Hopkins Hosp. Date signed 12-24-45

VS 150

G35:190
JL - 97630

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. G35:190

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 406 N. Poppleton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Myrtle Clash

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Clarence
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) March 2, 1901
8. AGE: Years 44 | Months 9 | Days 18 | If less than one day hr. min.
9. Birthplace ? (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name William
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 25, 1945 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem.
Location Balto County Md

18 (a) Funeral director Mrs. Robert A. Elliott & Son
(b) Address 1129 N. Carrollton Ave.

DEC 24 1945 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 20, 1945 at 5:30PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1, 1945 to Dec. 20 1945, and that I last saw h. alive on Dec. 20 1945.

Immediate cause of death: Cerebral hemorrhage
Due to: t
Due to:
Other Conditions: Arteriosclerosis
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation: —
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address B. C. H. Date signed 12-21-45

X

G35491

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

181

G35491 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful[ly] correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dukeland & Rayner Sts.
(c) Hospital or institution:
West Balto. Gen. Hosp. 20
(d) Length of stay in hospital or inst. (yrs., mos., or days) ½ day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2516 W. Fayette St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick W. Schmidt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M.

5. Color or race White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/12/863

8. AGE: Years 82 | Months | Days 9 | If less than one day hr. min.

9. Birthplace Germany.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Mrs. Hoffman.
(b) Address

17 (a) Burial (b) Date thereof 12-24-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location

18 (a) Funeral director Wm. J. Baker & Son
(b) Address York & Penn Ave

(a) DEC 24 1945 (b) Timothy J. Williams M.D.
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-21-45 1945 at 2:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-20 1945 to 12-21 1945 and that I last saw h[im] alive on 12-21 19

Immediate cause of death: Shock & Toxemia — Duration

Due to 3° burns over 50% of body (upper)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident (Burn)
(b) Date of occurrence 12-20 at 12 P. M
(c) Where did injury occur? Balto. Md.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home. While at work?
(Specify type of place)
(e) Means of injury Clothes ignited while firing fire

23. Signature Albert C. Hoffman Md M. D.
Address 2815 Ashland Date signed 12-24

Howard J. Hoffman Ave M.D. X

G35192

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1248

Registered No. G35192

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution: Mansford General Hospital 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 mo.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Roland Park Apts. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Dr. Reginald D. West

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Violet LaFleur West
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/12/1883

8. AGE: Years	Months	Days	If less than one day
62	3	10	hr. min.

9. Birthplace Montgomery Co. (Town, county, and state)
10. Usual Occupation Occulist
11. Industry or business Self

FATHER
12. Name Amos K. West
13. Birthplace Md.

MOTHER
14. Maiden Name Marian Cross
15. Birthplace Md.

16 (a) Informant Mrs. Violet L. West
(b) Address Roland Park Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/24/45 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

DEC (a) 24 1945 (Date received by Registrar) (b) Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/22 1945, at 7:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/3 1945, to 12/22 1945; and that I last saw h[im] alive on 12/21 1945.

Immediate cause of death	Duration
Cachexia	1 yr.
Portal Cirrhosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(c) Means of injury

23. Signature Martin E. Strobel M. D.
Address Md. Gen'l Hospital Date signed 12/23/45

Hartley for Williams, M.D.

635193

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 106 B

635193
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene Sts
(c) Hospital or institution: University Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days) 6 DAYS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County CARROLL
(c) City or town MANCHESTER
(If outside city or town limits, write RURAL and give town)
(d) Street No. —
(If rural give location)
(e) Citizen of foreign country? NO. (Yes or No)
If yes, name country

3 (a) FULL NAME ELLEN Jane KOLSCHER

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. W. DOWED

6 (b) Name of husband or wife Louis D. Kolscher
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan. 1, 1867

8. AGE: Years 78 | Months 11 | Days 20 | If less than one day — hr. — min.

9. Birthplace MARYLAND (Carroll Co.)
(Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business —

FATHER 12. Name Henry BURKHEIMER
13. Birthplace GERMANY

MOTHER 14. Maiden Name MINDIE SCHLA[illegible]
15. Birthplace GERMANY

16 (a) Informant ELMER KOLSCHER
(b) Address 2223 N. PULASKI ST.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/24/45 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 Date rec'd DEC 24 1945 (b) Planting for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-21 1945, at 7:12 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-15 1945 to 12-31 1945 and that I last saw h[illegible] alive on 12-21 1945.

Immediate cause of death PNEUMONITIS — Duration 3 wks.

Due to BRONCHIECTASIS — 41 yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation NONE

Major findings of operation:

of autopsy: NONE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Richard Norman M.D. / W. C. Ewing M. D.
Address University Hosp. Date signed 12-21-45

VS 3

G35494

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 109a

Registered No. G35494

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 7010 Park Heights Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 7010 Park Heights Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: EMILY PAGE

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: John G. Page
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Jan. 11, 1866

8. AGE: Years: 79 | Months: 11 | Days: 10 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name - Junger
13. Birthplace: Germany

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant: Mrs. Evelyn Eyer
(b) Address: 6522 Ridgewood Ave., Chevy Chase

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/24/45 (month) (day) (year)
(c) Cemetery or crematory: Balto. Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) DEC 24 1945 (Date rec'd by Registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-21 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1939, to Dec 21 1945, and that I last saw h[illegible] alive on 12-21 1945.

Immediate cause of death	Duration
Pneumonia	
Due to Hypertension	
Due to Generalized Art. Sclerosis	
Other Conditions	over

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Bernard Cohen M. D.
Address Marlboro Md. Date signed 12-27-45

VS 150

G35495

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G35495 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Ave.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Dickeyville (If outside city or town limits, write RURAL and give town)
(d) Street No. 5107 Westtendsville (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William H Edmonston

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Fannie Edmonston
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 9, 1876

8. AGE: Years	Months	Days	If less than one day
69	3	14	hr. min.

9. Birthplace Dickeyville, Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Robert Edmonston
13. Birthplace Maryland

MOTHER
14. Maiden Name Unknown
15. Birthplace Maryland

16 (a) Informant Mr. W. H. Edmonston
(b) Address 5107 Wetheredsville Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 26, 1945 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cemetery
Location Woodlawn, Md.
18 (a) Funeral director Miller & Lamotte
(b) Address 4610 Liberty Heights Ave.
19 Filed DEC 24 1945 (Date received by registrar) (b) Permit issued

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/23 1945 at 6:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/16 1945 to 12/23 1945 and that I last saw h alive on 12/23 1945

Immediate cause of death Acute Cardio-Respiratory Insufficiency.

Due to Bilateral hypostatic pneumonia.

Due to Chronic Cortonic Sclerotic Cardio-Vascular disease.

Other Conditions Diabetes Mellitus.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Cortlandt T. Hall Jr. M. D.
Address St. Agnes Hosp Date signed 12/23/45

VS 150

935

G35196

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

Registered No. G35196

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution:
University Hospital 17

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore #7
(If outside city or town limits, write RURAL and give town)
(d) Street No. 531 Oxford St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME James Dennis

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	negro	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) April 12 1905

8. AGE: Years	Months	Days	If less than one day
40	8	10	— hr. — min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business —

FATHER
12. Name Albert Dennis
13. Birthplace S. C.

MOTHER
14. Maiden Name Emma Eldridge
15. Birthplace Va.

16 (a) Informant Annie Holmes (Sister)
(b) Address 1026 W Franklin St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/24/45 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Pk
Location Balto County Md.

18 (a) Funeral director Charles Harper
(b) Address 512 Candleton Ave

19 DEC 24 1945 (b) Hunting for Work, Baltimore, Md.
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/22 1945, at 8:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/19 1945 to 12/22 1945, and that I last saw him alive on 12/22 1945

Immediate cause of death Hypertensive cardio-vascular disease — Duration 6 mos

Due to Cardiac failure

Due to —

Other Conditions Generalized arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address University Hosp. Date signed 12/22/45

VS 3

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35497 Seuberth

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √61

Registered No. G35497

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ~~JOHNS HOPKINS HOSPITAL~~
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 530 N Caddis St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Elizabeth Seuberth.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	White	married

6 (b) Name of husband or ~~wife~~ Seraphin Seuberth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 24, 1872

8. AGE: Years	Months	Days	If less than one day
73	2	29	hr. min.

9. Birthplace Sykesville, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Nickoles
13. Birthplace unknown

MOTHER
14. Maiden Name Smithline
15. Birthplace unknown

16 (a) Informant ~~JOHNS HOPKINS HOSPITAL~~
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/27/45 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Holy Redeemer
Location Belair Rd. Balto. Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street

19 (a) [illegible] Huntington for Wilkinson Registrar
(Date received by registrar) DEC 24 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12.23 1945 at 1 15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12.23 1945 to 12.23 1945, and that I last saw h[illegible] alive on 12.23.1945.

Immediate cause of death	Duration
Diabetic acidosis and coma	
Due to Diabetes mellitus	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John A Gruner M.D.
Address Johns Hopkins Date signed 12/27/45

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35498

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170c

G35498 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 611 N. Luzerne Avenue
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH BITTER

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-10-3669

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of ~~husband~~ or wife Mary E. (nee Schmitt)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 8, 1892

8. AGE: Years	Months	Days	If less than one day
53	1	15	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business Lucas Brothers

FATHER
12. Name Joseph Bitter
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Catherine Polster
15. Birthplace Baltimore, Md.

16 (a) Informant Joseph P. Bitter - son
(b) Address 611 N. Luzerne Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/26/45 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Moreland Mem. Park
Location Taylor Ave. Balto. Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2801-05 E. Madison Street

19 (a) DEC 24 1945 (Date rec'd by registrar) (b) Filing [illegible]

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 23, 1945, at 1:45 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Skull, Crushed leg, left

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-23-45 at 1:15 A. M. 7-2
(b) Where did injury occur? E. Monument St. & Luzerne Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian struck by auto.

23. Signature Robert Lee Fontaine M.D.
Medical Examiner.
Date signed Dec 23 1945

G35199

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170 C

G35199 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Johns Hopkins Hospital D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 703 N. Streeper Street
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country.....

3 (a) FULL NAME HILDA C. PRELL

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	single

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 3, 1905

8. AGE: Years	Months	Days	If less than one day
40	-	20	....hr. ....min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation.....
11. Industry or business Leboe Brothers

FATHER
12. Name George M. Prell
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Julia Ruth
15. Birthplace Baltimore, Md.

16 (a) Informant Doris M. Keil - sister
(b) Address 703 N. Streeper St.

17 (a) Burial (b) Date thereof 12/26/45
(Burial, cremation, or removal) (mouth) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Balto. Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison St.

19 (a) DEC 24 1945 (b) Curtis Leo Williams
(Date rec'd by Local Reg.) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 23, 1945 at 1:45 A. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Skull
Crushed leg, left.

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-23-45 at 1:15 A. M. 7-2
(b) Where did injury occur? E. Monument St. & Luzerne Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian struck by auto.

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Dec 23 - 1945

635500

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 635500

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: South Balto. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 day
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Riviera Beach
(If outside city or town limits, write RURAL and give town)
(d) Street No. Main Ave.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME NATILIE A. Hohman

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife Henry J. Hohman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 9, 1870

8. AGE: Years 75 | Months 10 | Days 13 | If less than one day ... hr. ... min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business —

FATHER
12. Name Charles A. Miller
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace ?

16 (a) Informant Mr. Charles Gehrmann
(b) Address Main Ave. Riviera Beach

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 26, 1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Fredrick Ave.

18 (a) Funeral director H. Sander & Sons.
(b) Address 1649 E. North Ave.

19 (a) DEC 24 1945 (Date rec'd by local reg.) (b) Hunting for Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-22 1945 at 3:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 8 1945 to Dec 22 1945 and that I last saw h[er] alive on Dec 22 1945.

	Duration
Immediate cause of death: Bronchopneumonia	
Due to: Exfoliative dermatitis	
Due to: and C-V arterio-sclerosis	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph S. Arduengo, M.D.
Address 1213 Light St Date signed 12-22-45

VS 150

G35501

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G35501

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not abbreviate. Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution:
Mansfield General

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3440 Ravenwood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Leonard Scroggs Sr.

3 (b) If veteran, name war: No

3 (c) Social Security Account No.: NO

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Bertha C. Barbour

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): June 10, 1869

8. AGE: Years 76 | Months 6 | Days 12 | If less than one day: hr. min.

9. Birthplace: Baltimore Maryland
(Town, county, and state)

10. Usual Occupation: Ice Dealer

11. Industry or business: Retired

FATHER
12. Name: William A. Scroggs
13. Birthplace: Baltimore Maryland

MOTHER
14. Maiden Name: Sarah ?
15. Birthplace: Baltimore Maryland

16 (a) Informant: William A. Scroggs
(b) Address: 3440 Ravenwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Dec. 26, 1945 (month) (day) (year)

(c) Cemetery or crematory: Parkwood
Location: Parkville

18 (a) Funeral director: H. Sander & Sons
(b) Address: 1649 E. North Ave.

DEC 24 1945
(Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/22 1945, at 8:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/22 1945 to 12/22 1945, and that I last saw h. alive on 12/22 1945.

Immediate cause of death

Bronchopneumonia — Duration: 2 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Martin E. Strobel M. D.

Address: Md. Gen'l Hospital Date signed: 12/23/45

G35502

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

G35502 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully recorded. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 28
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.D.A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 2910 Oakhill Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles W. Richardson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Bertha E Richardson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 16 1896

8. AGE: Years 49 | Months 2 | Days 6 | If less than one day hr. min.

9. Birthplace Brooklyn N.Y. (Town, county, and state)

10. Usual Occupation Marine Engineer

11. Industry or business U.S. Govt.

FATHER 12. Name Charles Richardson

FATHER 13. Birthplace West Indies

MOTHER 14. Maiden Name Eugenia E Stevens

MOTHER 15. Birthplace East Indies

16 (a) Informant Bertha E Richardson

(b) Address 2910 Oakhill Ave

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof Dec 26 1945 (month) (day) (year)

(c) Cemetery or crematory London Park

Location Baltimore Md.

18 (a) Funeral director Harry A. Amaral

(b) Address 4204 Ridgewood Ave

19 DEC 24 1945 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/22 1945 at 5 P.M.

21. I certify that I took charge of the remains described above, held an Inspection-Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature R. J. Sulinski M.D. Medical Examiner.

Date signed 12/23/45

VS 151

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

635503 — — 108

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 635503

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1408 McRoyal Av
(c) Hospital or institution: at Home 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 85 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltotety
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1408 McRoyal Av
(If rural, give location)
(e) Citizen of foreign country? Not (Yes or No)
If yes, name country

3 (a) FULL NAME Hilda Shutt

3 (b) If veteran, name war: no
3 (c) Social Security Account No. none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Augustus L. Shutt
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) April 25 1856

8. AGE: Years 89 | Months 7 | Days 27 | If less than one day: 26 hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation none

11. Industry or business none

FATHER — 12. Name Could not ascertain
13. Birthplace " " "

MOTHER — 14. Maiden Name Could not ascertain
15. Birthplace " " "

16 (a) Informant Miss L. Laubheimer (daughter)
(b) Address 1408 McRoyal

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-24-45 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Baltimore

18 (a) Funeral director Steward Mayer Co.
Address 108 W Preston

DEC 24 1945

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 21 1945 at 1 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 16 1945 to Dec 21 1945 and that I last saw h... alive on ... 19...

Immediate cause of death: Pneumonia (bobar) — Duration: 5 days
Due to:
Due to:
Other Conditions: arterio sclerosis hypertension
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Walter L. Dublin M. D.
Address 2220 Harlem Date signed

Dec 29/45

G35504

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G35504

Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 W. 40th. St
(c) Hospital or institution:
Home for Incurables
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs. 5 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County —
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Mrs Fanny P. Ryan Gillespie

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Alexander Bayne Gillespie.
6 (c) If alive, give age 91 years

7. Birth date of deceased (mo., day, yr.) Dec. 29-1863

8. AGE: Years	Months	Days	If less than one day
81	11	25	____ hr. ____ min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Home wife
11. Industry or business —

FATHER
12. Name John Ryan
13. Birthplace Green Spring Valley Md.

MOTHER
14. Maiden Name Susan Keenan
15. Birthplace Baltimore Md.

16 (a) Informant E Hartman
(b) Address Home for Incurables

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-26-45 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore

18 (a) Funeral director Sherwood Myers Co.
(b) Address 1501 Eutaw Place

19 (a) DEC 24 1945 (b) (Date rec'd by registrar) Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH December 23 1945 at 11:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/15 1943 to 12/23 1945, and that I last saw Mrs. alive on 12/22 1945.

Immediate cause of death	Duration
Bronchopneumonia	2 Days
Due to Cardiac Decompensation (only)	4 Days
Due to Hypertensive Cardio-Vascular Renal Disease	1 Years
Other Conditions Right Cerebral Vascular Accident	2 years

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation —
of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury —

23. Signature W. Hratton Dorsey M. D.
Address 1 E Mulberry St Balto Md. Date signed 12/27/45

G35505

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

Registered No. G35505

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4703 Stansbury Rd
(c) Hospital or institution: Pine Ridge Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Wentworth Rd
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Teresa Ostendorf

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none
4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Frank Ostendorf
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) Aug-10-1868
8. AGE: Years 77 | Months 4 | Days 12 | If less than one day: hr. min.
9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation none
11. Industry or business none

FATHER
12. Name
13. Birthplace Germany

MOTHER
14. Maiden Name
15. Birthplace Germany

16 (a) Informant Mrs J F Goodrich daughter
(b) Address Wentworth Rd
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-26-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore
18 (a) Funeral director Sherard Mayne Co.
(b) Address 1048 W Fort Ave
19 (a) DEC 24 1945 (Date rec'd by registrar) (b) Thomas J. Williams, Jr. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 22 1945 at 5 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1945 to Dec 22 1945; and that I last saw deceased alive on Dec 22 1945.

	Duration
Immediate cause of death: Bronchial Pneumonia	3 days
Due to: Heart Block	52 days
Due to: arteriosclerosis	3 ?
Other Conditions: Fracture of left hip (Include pregnancy within three months of death)	
Date of operation: 12-22	
Major findings of operation: none	
of autopsy: No	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature I. L. Keyser M. D.
Address Wentworth Rd Date signed Dec 26 46

635506

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. 635506

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2336 Fleet Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2336 Fleet Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Antoni Binkowski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Male | 5 Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Victoria

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name —
13. Birthplace Poland

MOTHER
14. Maiden Name —
15. Birthplace Poland

16 (a) Informant Victoria Binkowski
(b) Address 2336 Fleet St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 26-45 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Balto Co.

18 (a) Funeral director Wm. S. Fialkowski
(b) Address 2007 Eastern Ave

DEC 24 1945 (a) (Date received by Local Registrar) (b) [illegible] Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 22, 1945; at 11:30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy - Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mercer M.D. Medical Examiner
Date signed December 22, 1945

635507

HB# 97926

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

635507
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 704 W. Mulberry St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Ingram

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Separated

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ??

8. AGE: Years 66?? Months Days If less than one day ....hr. ....min.

9. Birthplace ?
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Irene ?
13. Birthplace ?

MOTHER
14. Maiden Name Irene?
15. Birthplace ?

16 (a) Informant Baltimore City Hospitals (Records)
(b) Address 4940 Eastern Ave.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 12-24-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore

18 (a) Funeral director Hilliard-Jackson
(b) Address 916 Penna. Ave

19 (a) DEC 24 1945 (Date filed by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 19, 1945, at 6:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 17, 1945 to Dec. 19, 1945 and that I last saw h. im alive on Dec. 19, 1945

Immediate cause of death Lobar pneumonia — Duration ?

Due to — Duration

Due to — Duration

Other Conditions A S H D c Mild failure — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Margaretta Dunn M. D.
Address B.C.H. Date signed 12/24/45

G35508

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G35508 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 623 Sarah Ann Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4-2
(e) Length of stay in Baltimore (yrs., mos., or days) 15 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 623 Sarah Anne Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SARAH ANN WALKER

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept, 28, 1902

8. AGE: Years 43 | Months 3 | Days 25 2/3 | If less than one day hr. min.

9. Birthplace Goldsboro, N.C. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Samuel Brown
13. Birthplace N.C.

MOTHER
14. Maiden Name Ella Harden
15. Birthplace N.C.

16 (a) Informant Roxanna Whalaian (Daughter)
(b) Address 623 Sarah Ann Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-24-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Maryland

18 (a) Funeral director William A. Jackson
(b) Address 916 Penna, Ave.

19 (a) DEC 24 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 21, 1945 at 3:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 15 1945 to Dec 21 1945 and that I last saw h.e. alive Dec 21 1945

Immediate cause of death Cerebral Hemorrhage
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration: 1 day

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. H. Watts M.D.
Address 715 Lemington Date signed 12/22/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully summed. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS 150

635509

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 170c

Registered No. 635509

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 15-4
(c) Hospital or institution: West Balto. General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2104 N. Fulton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elsie Ward

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband ~~or wife~~: Lee L. Ward

6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) May 18, 1892

8. AGE: Years 53 | Months 7 | Days 5 | If less than one day hr. min.

9. Birthplace Carroll Co Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Jabez N. Barnes
13. Birthplace Maryland

MOTHER
14. Maiden Name Kittie E. Harris
15. Birthplace Maryland

16 (a) Informant Lee L. Ward
(b) Address 2104 N. Fulton Ave · Balto

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 12-27-45 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Providence
Location Sumbro, Carroll Co. Md

18 (a) Funeral director E. M. Wall
(b) Address Westfield. Md

19 (a) DEC 31 1945 (Date rec'd by Registrar) (b) Huntington Hills, N.Y.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 23 1945 at 10 9 M.

21. I certify that I took charge of the remains described above, held an partial autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to hsn death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Intra Cranial Hemorrhage, traumatic

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☑ cause of death, fill in the following: 15-4
(a) Date of injury December 23 1945 9:45 A.M.
(b) Where did injury occur? Fulton + Lemmon Ave
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury Struck by auto

23. Signature Robert L. Fraser M.D. Medical Examiner.
Date signed 12-24-45

G35510

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

Registered No. G35510

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: Johns Hopkins Hospital 5-
(d) Length of stay in hospital or inst. (yrs., mos., or days) D-0-A
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1120 E Lexington Street
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Mary Marino Tutado

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife .....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 12/14/17

8. AGE: Years 28 | Months — | Days 7 | If less than one day ..... hr. ..... min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business .....

FATHER
12. Name Anderson Tutado
13. Birthplace portuguese

MOTHER
14. Maiden Name Fannie Milburn
15. Birthplace md

16 (a) Informant Lillian Tutado
(b) Address 1120 E. Lexington St

17 (a) Burial (b) Date thereof 12/24/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Olivet Cemetery
Location A a 6 Rd

18 (a) Funeral director Robert E Williams
(b) Address 1515 Mc Elderry St

19 (a) DEC 24 1945 (b) Huntington Williams, MD
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 21, 1945, at 9 35 P. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bullet wound of Brain

Due to .....

Other Conditions .....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-21-45 at 9.30 P. M.
(b) Where did injury occur? Found lying in front of 1121 E. Lexington St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no
(d) Means of injury Firearms (revolver)

23. Signature Howard J. Mullen M.D.
Medical Examiner.
Date signed 12-22-45

635511

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95B

Registered No. 635511

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dukeland + Raymor
(c) Hospital or institution: West Balto. Gen. Hosp. 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Entire Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2913 Windsor
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Stephen Jacob Clark

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	218-10-8195

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Ruth Duncan Clark
6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) 9 Aug. '03

8. AGE: Years	Months	Days	If less than one day
42	4	14	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Clerk.
11. Industry or business Apartment (Northway)

FATHER
12. Name Francis Bozard Clark
13. Birthplace Washington, D.C.

MOTHER
14. Maiden Name Frances Helen Donavan
15. Birthplace Baltimore

16 (a) Informant Mrs. Frances H. Clark.
(b) Address 3106 Ferndale Ave Balt.

17 (a) Burial (b) Date thereof 12/27/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) DEC 24 1945 (b)
(Date rec'd by registrar) Registrar, M. D.

MEDICAL CERTIFICATION

20. **DATE OF DEATH** 23 December 1945 at 3:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 23 Dec 1945 to 23 Dec 1945, and that I last saw h[illegible] alive on 23 Dec 1945.

Immediate cause of death	Duration
Resp. Cessation	
Pulmonary Edema.	
Due to Rt + Lt. Sided Heart Failure	
Due to Rheumatic Heart Dis.	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leslie G. Stahl Jr. M. D.
Address Fred Baetjer Gen Hosp Date signed 23 Dec 45

VS 150

635512

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. 635512

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully written. Physicians: please write the causes of death clearly and legibly. Be correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours Hosp. 20
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2515 W. Fayette St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Sarah A. Grentz

3 (b) If veteran, name war: --

3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife: Lawrence G. Grentz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Feb. 13, 1872

8. AGE: Years	Months	Days	If less than one day
73	10	9	hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: At Home
11. Industry or business

FATHER
12. Name: Michael E. Mooney
13. Birthplace: Ireland

MOTHER
14. Maiden Name: Sarah Cunningham
15. Birthplace: Pa.

16 (a) Informant: Miss Virginia Mooney
(b) Address: 5102 Norwood Ave. 7

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/26/45 (month) (day) (year)
(c) Cemetery or crematory: Woodlawn Cem.
Location: Woodlawn, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) DEC 24 1945 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 | 22 | 1945 at 9:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/20/1945 to 12/22/1945 and that I last saw her alive on 12/22/1945.

Immediate cause of death	Duration
Acute Congestive Heart Failure	
Due to Gen'l Arterio-Sclerotic Cardio-Vasc. Disease	72 hrs
Due to Hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation: None
Major findings of operation: None
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: J. Chase Norton Jr. M.D.
Address: Bon Secours Hosp. Date signed: 12/22/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful... correct age is especially important. Physicians: please write the...

G35513

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45c

Registered No. G35513

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 3
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2305 Sidney Ave. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Frank Snyder

3 (b) If veteran, name war: none
3 (c) Social Security Account No. none

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: --
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 30, 1885

8. AGE: Years	Months	Days	If less than one day
60	5	23	..... hr. ..... min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation.....
11. Industry or business.....

FATHER
12. Name Frederick Snyder
13. Birthplace Westport, Conn.

MOTHER
14. Maiden Name Mary E. Summers
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Mary E. Snyder
(b) Address 2305 Sidney Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/26/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) DEC 24 1945 (Date rec'd by registrar) (b) [illegible] M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/23/45 19.... at 8 00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/12 1945, to 12/23 1945, and that I last saw h.i.m alive on 12/23 1945.

Immediate cause of death	Duration
Carcinoma of mouth & left entrum	
Due to.....	
Due to.....	
Other Conditions.....	

(Include pregnancy within 3 months of death)
Date of operation 12/13/45
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at.....M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....
23. Signature R. G. Canner, M. D.
Address..... Date signed.....

VS 180

6

X

635514

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

635514 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address St. Paul & 23rd Sts.
(c) Hospital or institution:
Dr. Beck's Sanatorium
(d) Length of stay in hospital or inst., (yrs., mos., or days) 9-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2009 E. 31st St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FREDA McDONALD

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife T. Edward McDonald
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 7, 1890

8. AGE: Years	Months	Days	If less than one day
55	10	14	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John F. Miller
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Augusta Genderizric
15. Birthplace Balto., Md.

16 (a) Informant Mr. T. Edward McDonald
(b) Address 2009 E. 31st St.

17 (a) Entombment (Burial, cremation, or removal) (b) Date thereof 12/24/45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Mausoleum
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

DEC 24 1945 (Date rec'd by Registrar) (b) Thaddeus Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 21, 1945, at 10:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1945 to Dec 21 1945 and that I last saw her alive on Dec 21 1945

Immediate cause of death Cerebral Hemorrhage — Duration 14 hrs
Due to
Due to
Other Conditions Diabetes mellitus. moderate
(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature Nathaniel M Beck M. D.
Address 2727 N Charles Date signed Dec 22-45

VS 150

83a

G35515

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 B

Registered No. G35515

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2139 Walbrook Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2139 Walbrook Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ABERILLA ABBIE HENRY

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Adam Henry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 27, 1860

8. AGE: Years	Months	Days	If less than one day
85	0	24	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Solomon Hodges
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Ann Cooper
15. Birthplace Md.

16 (a) Informant Mr. Joseph A. McCauley
(b) Address 2139 Walbrook Ave.

17 (a) Burial (b) Date thereof 12/24/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (b)
(Date received by local registrar) (Signature of local registrar)
DEC 24 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 21, 1945 at 8:25 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 14 1945 Dec 21 1945
and that I last saw her alive on Dec. 21, 1945.

Immediate cause of death Acute dilatation of Heart — Duration

Due to Arteriosclerosis of valves & mitral

Due to Age advanced

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Eugene Pratt M. D.
Address 2202 N. North Ave. Date signed 12-22-45

G35516

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. G35516

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette Ave & John St
(c) Hospital or institution: Hospital for Women of Maryland. 14-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Mayland (b) County
(c) City or town Baltimore, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1409 John Street. (If rural, give location)
(e) Citizen of foreign country? no. (Yes or No) If yes, name country

3 (a) **FULL NAME** Volear Virginia Hartman.

3 (b) If veteran, name war none

3 (c) Social Security Account No. None.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Isaac Henry Hartman (Deceased) 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 11 · 1876

8. AGE: Years 69 | Months 1 | Days 10 | If less than one day hr. min.

9. Birthplace Ellicott City, Maryland. (Town, county, and state)

10. Usual Occupation None.

11. Industry or business None.

FATHER
12. Name Samuel Davis.
13. Birthplace Ellicott City, Md.

MOTHER
14. Maiden Name Volear Mellon.
15. Birthplace Ellicott City, Md.

16 (a) Informant Hospital Admission
(b) Address Record.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12/24/45 (month) (day) (year)

(c) Cemetery or crematory CATHEDRAL
Location

18 (a) Funeral director Chas J. Evans & Son
(b) Address 118 N. Mt. Royal Ave

19 (a) DEC 24 1945 (Date received by local registrar) (b) Filing No. Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH DEC 21 1945, at 9:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 8 1945, to Dec 21 1945, and that I last saw h.e.r. alive on Dec 21 1945.

	Duration
Immediate cause of death: Myocardial insufficiency	unknown
Due to: Coronary occlusion	
Due to: Arteriosclerotic Heart Disease	25 yrs.
Other Conditions: Primary atypical pneumonia. (Include pregnancy within 3 months of death)	16 days.

Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William H. Henninger. M. D.
Address Hosp. for Women of Md Baltimore (17) Md Date signed 12-24-45

635517

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. 635517

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Cal-a Sanatorium
(c) Hospital or institution: Mercy 15

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 50yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4341 Reisterstown Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Cicero

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	M.

6 (b) Name of husband or wife Mrs. Angelina Cicero
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1, 1882

8. AGE: Years	Months	Days	If less than one day
63	6	25	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Shoe Repairer
11. Industry or business

FATHER
12. Name Vincent Cicio
13. Birthplace Italy

MOTHER
14. Maiden Name Rosaria Zito
15. Birthplace Italy

16 (a) Informant Wife
(b) Address 4341 Reisterstown Rd., Balto

17 (a) Burial (b) Date thereof Dec 26-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Frederick Road

18 (a) Funeral director Frank V. Pelaitore
(b) Address 29 N.E. Balto. Md.

19 (a) DEC 24 1945 (b) Wallington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/22/45 19 , at 11:35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/8 1945 to 12/22 1945 and that I last saw h/ alive on 12/21 1945.

Immediate cause of death	Duration
Cardio-Respiratory failure	4 hours
Due to Cerebral Vascular Accident	10 days
Due to	
Other Conditions Stomach Abdominal Surgery	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul A. Meyers M. D.
Address Mercy Date signed 12/27/45

VS 150

635518

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 50

Registered No. 635518

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 415 Bruce St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 - 1
(e) Length of stay in Baltimore (yrs., mos., or days) 22 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 415 Bruce St.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie Jettie Elliott.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married.

6 (b) Name of husband or wife Geo. W. Elliott.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May-22-1875

8. AGE: Years	Months	Days	If less than one day
70	7	0	hr. min.

9. Birthplace St. Mary's Co. Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home.

FATHER
12. Name Marcellous Gatton.
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth McGill.
15. Birthplace Md.

16 (a) Informant Mrs. W. Ford Elliott.
(b) Address 772 Gently St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 26-45. (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore Md.

18 (a) Funeral director Charles J. Schurb.
(b) Address 505 N. Monroe St.

19 DEC 24 1945 (Date rec'd by Registrar) (b) Huntington Williamsport

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 22 1945, at 11:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 8 1945 to Dec 22 1945 and that I last saw h[illegible] alive on Dec 19 1945

Immediate cause of death Uraemia
Cancer

Duration
over

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation No operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence None at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. H. Lann M. D.
Address 1215 Hanover Date signed Dec 24/45

30

X

635719

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. 635519

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2239 Elsbare St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-4
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Balto (b) County
(c) City or town Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2239 Elsbare St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary A. Courtin

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 17th 1875

8. AGE: Years	Months	Days	If less than one day
70	1	5	hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name Michael J. Courtin
13. Birthplace Ireland

MOTHER
14. Maiden Name Anna B Martin
15. Birthplace Chicago Ill.

16 (a) Informant Mrs Sipp
(b) Address 2239 Elsbare St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 21st 1945 (month) (day) (year)

(c) Cemetery ~~or crematory~~ St Peters
Location Bentalow St

18 (a) Funeral director Leo G. Cook
(b) Address 1701-03 N Patterson Park Ave

19 (a) Dec 21 1945 (b) Livingston Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Wed 19 2nd 1945, at 5:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 15 1936 to 12/22 1945 and that I last saw her alive on 12/20 1945.

	Duration
Immediate cause of death Coronary Thrombosis	15 minutes
Due to Coronary Sclerosis	4 yrs
Due to arteriosclerotic Cardio-vascular Disease	10 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. K Grossman M. D.

Address 2122 N. Patterson Date signed 12/24/45

J. Kram Grossman

VS 190

G35520

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55 E

G35520 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1 E Pond 31st
(c) Hospital or institution:
The Hopkins Apartments
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1 E Pond 31st.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William C Yarborough

3 (b) If veteran, name war: W

3 (c) Social Security Account No.: none

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Bertie Hanson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 16 1864

8. AGE: Years 81 | Months 2 | Days 5 | If less than one day hr. min.

9. Birthplace Wilmington N C
(Town, county, and state)

10. Usual Occupation Lead Trimmer Retired

11. Industry or business A C L R R

FATHER
12. Name Oscar Yarborough
13. Birthplace N C

MOTHER
14. Maiden Name Margaret Smith
15. Birthplace N C

16 (a) Informant Mrs Butie Yarborough
(b) Address 403 Hopkins Apt

17 (a) Removal (b) Date thereof 12/24/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oakdale
Location Wilmington N C

18 (a) Funeral director Wilson York Inc
(b) Address 1217 E Pond St

19 (a) (Date received by registrar) (b) Williams MD Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 23 1945 at 7.9 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1938 to Dec 23 1945 and that I last saw him alive on Dec 22 1945

Immediate cause of death: Cardio Pulmonary Failure — Duration: months

Due to Squamous cell Carcinoma of right hand — years

Due to

Other Conditions Carcinoma - Pulmonary — years

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] Henson M. D.

Address 20 E Preston St Date signed 12/24/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

635521 93D

Registered No. 635521

635521

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3117 Woodhome Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Unknown

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3117 Woodhome Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MARIA A. GRUNDMAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	widowed

6 (b) Name of husband or wife Frederick Grundman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 3rd. 1878

8. AGE: Years	Months	Days	If less than one day
67	4	19	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name William Schle berger
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mr. Paul Grundman
(b) Address White Hall Md.

17 (a) Burial (b) Date thereof 12/26/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Johns Lutheran
Location Parkville, Maryland

18 (a) Funeral director Loseaty Funeral Home
(b) Address 7401 Belair Road

19 (a) (b)
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 22, 1945, at 7 40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 19 1945 to Dec 22 1945 and that I last saw h[er] alive on Dec 22 1945

Immediate cause of death Cardiac decompensation — Duration Dec 19 1945

Due to

Due to

Other Conditions Chronic myocarditis 7 years, arteriosclerosis a months
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Francis B. Green M.D.
Address 300 Georgia Ave Baltimore Md. Date signed Dec 23/45
M. D.

G35522

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G35522 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 00a
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 613 E. Baltimore
(If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME Earle Simpson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife.....

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years 60 | Months | Days | If less than one day hr. min.

9. Birthplace Unknown
(Town, county, and state)

10. Usual Occupation.....

11. Industry or business

FATHER 12. Name Unknown
13. Birthplace ,

MOTHER 14. Maiden Name ,
15. Birthplace ,

16 (a) Informant Daniel Nelson
(b) Address 12 N. Gorsuch St

17 (a) Burial (b) Date thereof 12/27/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Mt. Olivet
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1317 St. Paul St

DEC 25 1945

19 (a) Clayton Williams, M.D. Registrar
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 24 1945, at 3.45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular disease

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed 12-24-45

G35523 BALTIMORE CITY HEALTH DEPARTMENT G35523
CERTIFICATE OF DEATH 82 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 W. 40th St.
(c) Hospital or institution:
Home for Incurables — 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 yrs. 4 mos. 24 da.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 700 W. 40th St
(If rural give location)
(e) Citizen of foreign country? No — (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Mary Blanche Fox.
3 (b) If veteran, name war —
3 (c) Social Security Account No. —
4. Sex F
5. Color or race W
6 (a) Single, married, widowed, or divorced W
6 (b) Name of husband or wife Francis J Fox
6 (c) If alive, give age Dead years
7. Birth date of deceased (mo., day, yr.) Sept. 1 1876
8. AGE: Years 69. Months 3 Days 25 If less than one day ____ hr. ____ min.
9. Birthplace Balto - Md —
(Town, county, and state)
10. Usual Occupation —
11. Industry or business —
FATHER 12. Name Robert Stewman.
13. Birthplace Balto. Md —
MOTHER 14. Maiden Name Mary Carbaugh
15. Birthplace Balto - Md —
16 (a) Informant Mrs. Wharton
(b) Address 700 W. 40th St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/27/45 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Balto. Md.
18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St
19 (a) 12-27-1945 (Date received by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION
20. DATE OF DEATH Dec. 24 1945, at 10 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 31 1945 to Dec. 24 1945, and that I last saw her alive on 12/23 1945

	Duration
Immediate cause of death: Bronchopneumonia	6 Days
Due to: Myelomatosis	6 years
Due to: Arteriosclerosis (Sen.) Essential Hypertension	10 years 10 years
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature W. Stratton Hersperger M. D.
Address 214 Medical Arts Bldg. Date signed 12/24/45

VS 8

G35524 ✓ G35524

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 930

Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1907 Edsir Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1907 Edsir Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ella Berkrich

3 (b) If veteran, name war: NF
3 (c) Social Security Account No.: none
4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Herman
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): Nov 10, 1868
8. AGE: Years 77 | Months 1 | Days 13 | If less than one day hr. min.
9. Birthplace: Hanover Germany (Town, county, and state)
10. Usual Occupation: Housework
11. Industry or business

FATHER 12. Name Unknown
13. Birthplace Germany
MOTHER 14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Ella M Berkrich
(b) Address 1907 Edsir Rd
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/27/45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Catonsville Md
18 (a) Funeral director Kilbourn Funeral Home
(b) Address 1217 E Fort Ave
19 (a) (Date received by registrar) (b) Registrar

DEC 29 1945

VS 150

Waiting for Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 23 1945, at 7:20 M
21. I certify that death occurred on the date above stated; that I attended deceased from Dec 21 1945 to Dec 23 1945 and that I last saw her alive on Dec 22 1945

	Duration
Immediate cause of death: Myocarditis	1 mo
Due to: Obesity, parenchymatous nephritis	about 1 week
Due to:	
Other Conditions: Cirrhosis - sclerosis (chronic)	?

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature: Frank D Tubby M. D.
Address 2225 Harrison Blvd Date signed Dec. 24/45

G35525

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 930

G35525 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please correct age is especially important. Every item of information should be carefully supplied. The space reserved for binding must be left clear. Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3402 Ingleside Ave Pres Lic'd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3402 Ingleside Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Edward Dickens

3 (b) If veteran, name war	3 (c) Social Security Account No.
W	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Marie Cecile Dickens
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 18th 1865

8. AGE: Years	Months	Days	If less than one day
80	3	5	hr. min.

9. Birthplace Greensboro Ala.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name John W. Dickens
13. Birthplace N.C.

MOTHER
14. Maiden Name Elizabeth Moore
15. Birthplace Livingston Ala.

16 (a) Informant Mrs Henry Guntrum
(b) Address 3402 Ingleside Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/26/45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (d) [illegible] Huntington Williams M.D.
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 23rd 1945, at 5 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1944 to Dec 23 1945, and that I last saw h[illegible] alive on Dec 23 1945.

Immediate cause of death Pulmonary Edema

Duration 2 days

Due to Hypertensive Cardio-Vascular Disease

Due to

Other Conditions Old cerebral vascular accident

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George Shanfas M.D.
M. D.
Address 5106 Park Heights Ave Date signed 12/24/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35526 Francis

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 117A

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Colvert Sts.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) 9

2. USUAL RESIDENCE OF DECEASED:
(a) State Virginia (b) County
(c) City or town Newport News (If outside city or town limits, write RURAL and give town)
(d) Street No. Holland Apts. 4 D (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Francis Anton Collier

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Mrs. Francis A. Collier

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 20th 1881

8. AGE: Years	Months	Days	If less than one day
64	2	4	hr. min.

9. Birthplace Hampton Virginia (Town, county and state)

10. Usual Occupation Banking business

11. Industry or business Clerk

FATHER
12. Name Howard S. Collier
13. Birthplace Virginia

MOTHER
14. Maiden Name Nannie Schmelz
15. Birthplace Virginia

16 (a) Informant Mrs. Francis A. Collier (wife)
(b) Address Holland Apts. 4D Newport News

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 12/25/45 (month) (day) (year)

(c) Cemetery or crematory Newport News
Location Va

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 DEC 25 1945 (Date received by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/24 1945; at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/16 1945 to 12/24 1945, and that I last saw him alive on 12/24 1945.

Immediate cause of death	Duration
Cardiac failure	2 days.
Due to Pulmonary edema	3 days
Due to Auricular fibrillation Generalized arteriosclerosis	4 days
Other Conditions Post operative gastric resection (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation: Penetrating peptic ulcer of pylorus
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Huntington Williams Jr. M. D.
Address Union Memorial Hosp Date signed 12-24-45

Huntington Williams, M.D.

X

G35527 RENA P. KARCHER G35527

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rockland & Laynor
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2½ days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1719 N. Bentalou St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Rena P. Karcher

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband: William H. Karcher Sr.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 11 1881

8. AGE: Years	Months	Days	If less than one day
64	9	12	hr. min.

9. Birthplace: Balto. Md. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business: At Home

FATHER
12. Name: Frederick S. Laib
13. Birthplace: Balto. Md.

MOTHER
14. Maiden Name: Lavina Crackers
15. Birthplace: Balto. Md.

16 (a) Informant: George W. Karcher
(b) Address: 2906 White Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/27/45 (month) (day) (year)
(c) Cemetery or crematory: London Park
Location: Balto. Md.

18 (a) Funeral director: William Cox Inc.
(b) Address: 1217 St. Paul St.

19 (a) DEC 27 1945 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 23 1945, at 10:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-20 1945, to 12-23 1945, and that I last saw her alive on 12-23 1945.

Immediate cause of death	Duration
Coronary Artery Disease and myocardial infarction	
Due to	
Due to	
Other Conditions Diabetes Mellitus	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert H. Baldwin M. D.
Address West Baltimore General Hospital Date signed 12-23-45

VS 150

94 A

G35528 BALTIMORE CITY HEALTH DEPARTMENT G35528

CERTIFICATE OF DEATH

30D

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 213 Goodale Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 213 Goodale Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph N. Leifert

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Elaine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 23 - 1889

8. AGE: Years 56 | Months 1 | Days 0 | If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joseph N. Leifert
13. Birthplace Balto.

MOTHER
14. Maiden Name Mary A. Hey.
15. Birthplace Balto.

16 (a) Informant Elaine Leifert
(b) Address 213 Goodddale Rd.

17 (a) Burial (b) Date thereof Dec 23-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Rood
Location Belair Rd.

18 (a) Funeral director John A. Mogan
(b) Address 3700 E. Balto. St.

DEC 25 1945

19 (a) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 23 1945, at 4P. M

21. I certify that death occurred on the date above stated; that I attended deceased from August 5 1944, to December 23 1945, and that I last saw h.. alive on December 23 1945.

	Duration
Immediate cause of death: Cardiac failure - sudden	more than 2 years
Due to: Aneurysm of the aorta	
Due to: Medical records	
Other Conditions: Gout	5 years

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard N. Tillman M.D.
M. D.

Address 3035 St. Paul St Date signed Dec 24, 1945

VS 150

X

G35529

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1930

G35529 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4613 York Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4613 York Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jean D. Miller

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Anna L.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 10-1873

8. AGE: Years 72 Months 5 Days 12 If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business Restaurant Prop

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace

16 (a) Informant Anna L. Miller
(b) Address 4613 York Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 26-45 (month) (day) (year)
(c) Cemetery or crematory Holy Red.
Location Belair Rd.

18 (a) Funeral director John. A. Hogan
(b) Address 4601 Greenmount Ave

19 (a) (b) Date rec'd by registrar Huntington Williams M.D. Registrar

DEC 26 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 22 - 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1945, to Dec 22 1945, and that I last saw him alive on Dec 20 1945

	Duration
Immediate cause of death Pulmonary Embolus	Sudden
Due to Coronary Thrombosis	6 mo
Due to Arterio - sclerotic cardio - vascular disease	years.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Anthony J. Thomas M. D.

Address 4602 York Rd Date signed 12-23-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35530
AB-98010

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G35530
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1day
(e) Length of stay in Baltimore (yrs., mos., or days) 65yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3504 E. Baltimore St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin Joseph Schaffer

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Catherine
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 13- 1875

8. AGE: Years	Months	Days	If less than one day
70	5	9	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Michael
13. Birthplace Germany

MOTHER
14. Maiden Name Mary ?
15. Birthplace Germany

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof Dec 26-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Red.
Location Belair Rd.
18 (a) Funeral director John A. Hogan
(b) Address 3000 E. Balto. St.
19 (a) (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 22- 1945, at 5.45PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-21- 1945, to 12-22- 1945, and that I last saw h im alive on 12-22- 1945.

Immediate cause of death Lobar Pneumonia — Duration
Due to
Due to
Other Conditions Cardiac insufficiency
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Margaret Hogan M. D.
Address B. C. H. Date signed 12/28/45

G3553

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

G3553 Registrar No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct date is especially important. Physicians: please write the causes of death clearly and legibly.

REGISTERED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address LAFAYETTE and JOHN ST.
(c) Hospital or institution:
Hospital for Women of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 122
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltic
(c) City or town Glyndon
(If outside city or town limits, write RURAL and give town)
(d) Street No. 211 Central Ave.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME LAURA THERESA ORRICK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife Frank Orrick

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 8 1871

8. AGE: Years	Months	Days	If less than one day
74	10	19	hr. min.

9. Birthplace CHESTER, PENNSYLVANIA
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name GEORGE PELL
13. Birthplace MARYLAND

MOTHER
14. Maiden Name MARY PELL
15. Birthplace MARYLAND

16 (a) Informant Mrs. E.O. Caples
(b) Address 211 Central Avenue; Glyndon Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 27-45 (month) (day) (year)

(c) Cemetery or crematory Greenmount Park
Location Balto. City

18 (a) Funeral director J.F. Gleim & Sons
(b) Address Reisterstown Md.

DEC 25 1945

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 25 DECEMBER 45 at 6 AM M

21. I certify that death occurred on the date above stated; that I attended deceased from 26 Aug 1943, to 25 Dec 1945, and that I last saw h PR alive on 25 Dec 1945.

Immediate cause of death ARTERIOSCLER-OSIS, General — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Richard Compton M. D.
Address Hospital for Women Date signed 25 Dec 1945

X

G35532

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G35532 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1929 West Fayette Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 Yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 25 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1929 West Fayette Street
(If rural give location)
(e) Citizen of foreign country? **** (Yes or No)
If yes, name country ****

3 (a) FULL NAME ALICE M. MEEKS

3 (b) If veteran, name war: No.

3 (c) Social Security Account No.: None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: William C. Meeks
6 (c) If alive, give age * years

7. Birth date of deceased (mo., day, yr.) 6/16/1865

8. AGE: Years 80 | Months 5 | Days 7 | If less than one day ********** hr. min.

9. Birthplace: Rock Hall Maryland (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business: At Home

FATHER
12. Name: Thomas R. Rich
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Mary Caldwell
15. Birthplace: Maryland

16 (a) Informant: Mr. William C. Murray
(b) Address: 1929 West Fayette St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 26 Dec. 45 (month) (day) (year)
(c) Cemetery or crematory: Still Pond Cemetery
Location: Maryland. (Eastern Shore)

18 (a) Funeral director: F.B.WIPPERT & SON
(b) Address: 1300 Eutaw Place

19 (a) DEC 25 1945 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 23 December 19 45, at 6:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-20- 19 45, to 12-23- 19 45, and that I last saw her alive on 12-22 19 45.

Immediate cause of death	Duration
Due to Chronic Myocarditis	Several Years
Due to old age	
Other Conditions Exhaustion	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herbert C. Blake M. D.
Address Medical Arts Building Signed 12/ /45

VS 150

G35533

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94A

G35533 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1218 North Bentalou St.
(c) Hospital or institution: 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1218 N. Bentalou St.
(If rural give location)
(e) Citizen of foreign country? ********* (Yes or No)
If yes, name country

3 (a) FULL NAME MARY ZOIDA FOXWELL

3 (b) If veteran, name war: No.

3 (c) Social Security Account No.: None.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Charles E. Foxwell

6 (c) If alive, give age: D. years

7. Birth date of deceased (mo., day, yr.) 17 June 1859

8. AGE: Years 86 | Months 6 | Days 6 | If less than one day ********** hr. ..... min.

9. Birthplace: Golden Hill Maryland
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business: At Home

FATHER
12. Name: Samuel A. Tyler
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Casann Gottee
15. Birthplace: Maryland

16 (a) Informant: Walter E. Foxwell
(b) Address: 814 N. Bentalou Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 27 Dec. 45 (month) (day) (year)
(c) Cemetery or crematory: Foxwell Cemetery
Location: Grapo Md. (Eastern Shore)

18 (a) Funeral director: F.B.WIPPERT & SON
(b) Address: 1300 Eutaw Place, c.

19 (a) 23 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 23 December 19 45 at 4:30 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-4 19 45 to 12-23 19 45, and that I last saw h er alive on 12-23 19 45

Immediate cause of death	Duration
acute coronary thrombosis	20 min.
Due to arteria pulmonis	2 months
Due to	
Other Conditions hypodegeneration	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury

23. Signature H.W.Scheye M. D.
Address 3921 Edmondson Ave Date signed 12-24-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

Dr. H.W.Scheye

G35534

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G35534 Registered No. 1318

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rutland, Raymon
(c) Hospital or institution:
West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mo 18 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2454 West. Baltimore St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country *********

3 (a) **FULL NAME** Gertrude E Emrhein (Gertrude E. Emrhein)

3 (b) If veteran, name war	3 (c) Social Security Account No.
No.	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	Married

6 (b) Name of husband or wife Thomas J. Emrhein
6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) 10/15/1898

8. AGE: Years	Months	Days	If less than one day
47	2	8	********* hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name George W. Thomas
13. Birthplace Maryland

MOTHER
14. Maiden Name Alvin a C. Schwartz
15. Birthplace Germany

16 (a) Informant Mr. Thomas J. Emrhein
(b) Address 2454 W. Baltimore St.

17 (a) Burial (b) Date thereof 26 Dec. 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Woodlawn Maryland

18 (a) Funeral director F.B.WIPPERT & SON
(b) Address 1300 Eutaw Place

19 (a) (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 23 1945 at 3 00 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-28 1945 to 12-23 1945; and that I last saw h.. alive on 12-23 1945

Immediate cause of death Chronic pancreatic diabetis

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. DeB. Baldwin M. D.
Address West Baltimore General Hospital signed 12-23-45

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35535

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 930

G35535 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 249 S. Hilton St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 249 S. Hilton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES P. MURPHY

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	213-01-5460

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Margaret V. Murphy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 14, 1886

8. AGE: Years	Months	Days	If less than one day
59	5	8	hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation Chauffeur
11. Industry or business Balto. Copper Paint Co.

FATHER
12. Name Thomas Murphy
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Appolina Smith
15. Birthplace Balto., Md.

16 (a) Informant Mr. Albert Kelly
(b) Address 257 S. Hilton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/26/45 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

DEC 27 1945
VS 150

MEDICAL CERTIFICATION P

20. DATE OF DEATH Dec. 22, 1945, at 10:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 22, 1945 to Dec. 22, 1945 and that I last saw him alive on Dec. 22, 1945.

Immediate cause of death	Duration
Acute Myocardial Failure	Immediate
Due to Chronic Myocarditis	4 years
Due to	
Other Conditions Asthmatic Bronchitis	4 years

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature Frank H. Ogden M. D.
Address 2701 N. Calvert St. Date signed Dec. 24, 1945

X

G35536 — BALTIMORE CITY HEALTH DEPARTMENT — G35536

CERTIFICATE OF DEATH 161 C

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2737 Booker Drive
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2737 Booker Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Preston Larkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-19-45

8. AGE: Years | Months | Days 4 | If less than one day hr. min.

9. Birthplace 2737 Booker Drive (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Carl Larkins
13. Birthplace Pender Cty N.C

MOTHER
14. Maiden Name Alberta DeMarard
15. Birthplace Balto Md

16 (a) Informant Carl Larkins
(b) Address 2737 Booker Dr.

17 (a) (Burial, cremation, or removal) (b) Date thereof 12 25 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cemetery
Location Balto.

18 (a) Funeral director Walter B. Young & Sons
(b) Address 1391 N. Hamlin St.

19. DEC 25 1945 (b) (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-23 1945, at 4.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-22-1945, to 12-23-1945, and that I last saw her alive on 12-23-1945.

Immediate cause of death Hemorrhagic Disease of New Born — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R L Jochem M.D.
Address 600 N. Broadway Date signed 12-25-45

VS 150

Huntington Williams, M.D.

G35537

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G35537 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: University Hosp. 4
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 155 W. Fayette
(If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME Mildred Lloyd-Love (E.R.)

3 (b) If veteran, name war: W

3 (c) Social Security Account No.: none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Milhorn E

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb 17. 1909

8. AGE: Years: 36 | Months: 10 | Days: 7 | If less than one day: ..... hr. ..... min.

9. Birthplace North Carolina
(Town, county, and state)

10. Usual Occupation Unknown

11. Industry or business

FATHER
12. Name Christopher S Brantley
13. Birthplace N. C.

MOTHER
14. Maiden Name Arredella A Hood
15. Birthplace N C

16 (a) Informant Lemmie Brantley
(b) Address Zebulon, N. C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/28/45 (month) (day) (year)
(c) Cemetery or crematory Zebulon
Location Zebulon - N C

18 (a) Funeral director Pelham Funeral Dir
(b) Address 1219 E Cont St

19 (a) DEC 25 1945 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 24 1945, at 4:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to h[illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
(a) Lobar Pneumonia

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed 12-24-45

VS 151

G35538

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945 D

G35538

Registered No. .....

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRESS WHILE PENCIL WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 307 Fount Hill Ave
(c) Hospital or institution: Franklin Square Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 307 Fount Hill Ave
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME John Steiger

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of ~~husband~~ or wife Jeannette Steiger
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 6, 1869

8. AGE: Years	Months	Days	If less than one day
76	6	17	..... hr. ..... min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Retired Upholsterer
11. Industry or business Miller Bros.

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name .....
15. Birthplace

16 (a) Informant Mrs. Marie B. Brooks
(b) Address 307 Fount Hill Ave.

17 (a) Burial (b) Date thereof 12-26-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore

18 (a) Funeral director Thomas J. Kenny Inc.
(b) Address Hollins & Fulton Sts

19 (a) DEC 25 1945 (b) Huntington Williams, M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 23 Dec 1945, at ..... M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio - Vascular disease

~~Disease~~

.....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury .....

23. Signature William G. Kelfeldt M.D.
Date signed 23 Dec 45 Medical Examiner

VS 151

G35539

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

168

G35539 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRINT WITH PENCIL, WHEN UNREADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1124 N. Eutaw St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1124 N. Eutaw St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dorothy F. Davis

3 (b) If veteran, name war: no

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Wilbur Davis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 24. 1916

8. AGE: Years 27 | Months 8 | Days — | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Harley Brown
13. Birthplace Iowa

MOTHER
14. Maiden Name Jessie Hopkins
15. Birthplace Baltimore Md

16 (a) Informant Mrs Jessie Smith
(b) Address 194 Edgevale Road

17. Burial (Burial, cremation, or removal) (b) Date thereof 12/28/45 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glen Burnie Md

18 (a) Funeral director Wilburn Cook Jr
(b) Address 1217 E Lombard St

DEC 26 1945 (Date rec'd by registrar) Huntington for Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 24 1945, at 11 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Strangulation, traumatic

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-7-45 at ? M.
(b) Where did injury occur? 1124 N. Eutaw St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Blunt Force

23. Signature Robert L. Graham M.D.
Medical Examiner.
Date signed 12-24-45

G35540

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

122 B

G35540 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution Mercy Hosp 8
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1620 N. Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country No

3 (a) FULL NAME John C. Pletcher

3 (b) If veteran, name war —
3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of ~~husband or~~ wife Emma Leonard
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 29, 1866

8. AGE: Years	Months	Days	If less than one day
79	4	26	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name John Pletcher
13. Birthplace Balto.

MOTHER
14. Maiden Name Barbara Buchheimer
15. Birthplace Balto

16 (a) Informant Edgar Wendover
(b) Address 27 Bedford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/27/45 (month) (day) (year)
(c) Cemetery or crematory Balto
Location Md

18 (a) Funeral director Wm. Cook Sons
(b) Address 1217 St. Paul St.

19 (Date received by registrar) DEC 26 1945 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/25 1945, at 2.35 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/24 1945, to 12/25 1945, and that I last saw him alive on 12/25 1945

Immediate cause of death	Duration
Heart failure	
¥ Shock	
Due to Intestinal obstruction	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: prostatic Ca ? sigmoid

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles Shaker Jr. M.D.
Address Mercy Hosp Date signed 12/26/45

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35541

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 33a

Registered No. G35541

1. PLACE OF DEATH:
(a) Baltimore City, Maryland —
(b) Street address
(c) Hospital or institution: Childrens Hospital School
(d) Length of stay in hospital or inst. (yrs., mos., or days) 62 days
(e) Length of stay in Baltimore (yrs., mos., or days) 62 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Talbot
(c) City or town Easton
(If outside city or town limits, write RURAL and give town)
(d) Street No. R D 1 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country —

3 (a) FULL NAME Ruth Catherine SHORTALL

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F. | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Child

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-4-42

8. AGE: Years 3 | Months 5 | Days 20 | If less than one day — hr. — min.

9. Birthplace Easton Talbot Co
(Town, county, and state)

10. Usual Occupation Child
11. Industry or business

FATHER
12. Name Percy J. Shortall
13. Birthplace Easton - Talbot Co.

MOTHER
14. Maiden Name Florence R. Mielke
15. Birthplace Talbot Co

16 (a) Informant Percy J Shortall
(b) Address Same as above

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 27/45 (month) (day) (year)
(c) Cemetery or crematory Springhill Cem.
Location Easton, Md.

18 (a) Funeral director Stewart & Maxwell Company
(b) Address 108 W. North Av. City.

19 DEC 26 1945 (Date received by local registrar) Huntington Williams (Registrar)

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 25 1945, at 8:30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-24 1945, to 12-25 1945, and that I last saw h[illegible] alive on Dec 24 1945.

Immediate cause of death Meningitis — Duration 24 hrs

Due to Grippe & Pneumonia — Duration 4 days

Due to —

Other Conditions Congenital Deformities

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury —

23. Signature Robert W Johnson M.D.
Address 4E Madison St Date signed 12-26-45
Bath X

G35542

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93D

G35542

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1138 Ething St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1138 Ething St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Janie Washington

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years 67 | Months | Days | If less than one day hr. min.

9. Birthplace Lowell N.C.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Adam Fox.
13. Birthplace N.C.

MOTHER
14. Maiden Name Susan Fox
15. Birthplace N.C.

16 (a) Informant Henrietta Frisco.
(b) Address 915 Harlem Ave

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof 12-26-45 (month) (day) (year)
(c) Cemetery or crematory Lowell Cem.
Location Lowell. N.C.

18 (a) Funeral director Chas. H. Alexander.
(b) Address 1200 McCulloh St.

19 (d) DEC 26 1945 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/22 1945, at 4 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C.V disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature P. J. Lubowski M.D.
Medical Examiner.
Date signed 12/25/45

VS 151

correct age is especially important. Physicians: please write the c

G35543 CERTIFICATE CORRECTED 10-24-56 ✓ G35543

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Ad. of Dentzon
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 33 days
(e) Length of stay in Baltimore (yrs., mos., or days) 33 days

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va. (b) County
(c) City or town New Martinsville (If outside city or town limits, write RURAL and give town)
(d) Street No. 164 North St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alexander C. Badaracco
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Married

6 (b) Name of husband or wife Mrs Valentine Badaracco
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1873

8. AGE: Years	Months	Days	If less than one day
72			hr. min.

9. Birthplace Sicily (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Charles Badaracco
13. Birthplace Sicily

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs Valentine Badaracco
(b) Address 164 North St, New Martinsville

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-28-45
(c) Cemetery or crematory Mt Calvary Cem
Location Martinsburg W. Va.

18 (a) Funeral director Leonard J. Kirk
(b) Address 5305 Harford Rd.

DEC 26 1945 (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 25 1945, at 11:55 P M
21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 22 1945, to Dec 25 1945, and that I last saw him alive on Dec 25 1945.

Immediate cause of death	Duration
Cardio-vascular failure	
Due to Pneumonia	2 days
Due to Carcinoma of sigmoid	unknown
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 12/20/45
Major findings of operation: Carcinoma of sigmoid
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature P.R. Myers M. D.
Address Mercy H. Date signed 12/26/45

Huntington-Williams, Md.

G35544

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G35544
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green
(c) Hospital or institution:
Univ — 7
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6003 Sefton Ave
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Lotta Diebrich

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Wh	Mar.

6 (b) Name of husband or wife Wm D.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years	Months	Days	If less than one day
71			hr. min.

9. Birthplace Md
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name James Fopplas
13. Birthplace South Carolina

MOTHER
14. Maiden Name — Worden
15. Birthplace Baltimore

16 (a) Informant Husband
(b) Address 6003 Sefton Ave

17 (a) Burial (b) Date thereof Dec 28
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Woodlawn

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans St

19 DEC 26 1945 (b) Huntington Williams M.D.
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-25 19 45 at 1:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-19 1945 to 12-25 1945 and that I last saw h[illegible] alive on 12-25 1945.

Immediate cause of death	Duration
Resp. failure	
Due to Cardiosclerosis	
Due to Diabetes.	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None —
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. I. Butler —
Address Univ Hosp Date signed 12-25-45 M. D.

635545

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

635545 Registered No.

Type, print or mimeograph. Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3131 Chesley Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town, plainly write RURAL and give town)
(d) Street No. 3131 Chesley Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Stewart

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 15, 1876

8. AGE: Years 69 | Months 11 | Days 9 | If less than one day hr. min.

9. Birthplace Balto; Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Nicholas Hager
13. Birthplace Germany

MOTHER
14. Maiden Name Kisling
15. Birthplace Germany

16 (a) Informant William Stewart
(b) Address 3131 Chesley Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/28/45 (month) (day) (year)
(c) Cemetery or crematory St Matthews
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2005 Oakdale Ave

19 (a) DEC 26 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 24 Dec 1945 at 7:20 P M

21. I certify that I took charge of the remains described above, held an Autopsy / Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH A Hypertensive Cardio Vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J. Helfrich M.D.
Medical Examiner
Date signed 25 Dec 45

635546

BALTIMORE CITY HEALTH DEPARTMENT ✓ 635546
CERTIFICATE OF DEATH 937 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fleet Sts
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) 74 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 223 N. Castle Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) **FULL NAME** Peter Fink

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife MINNIE FINK

12-9-1871 If alive, give ~~age~~ years

7. Birth date of deceased (mo., day, yr.) 12/(9)/71

8. AGE: Years 74 | Months 0 | Days (7)14 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Retired Chemist

11. Industry or business

FATHER 12. Name Dont Know

13. Birthplace Germany

MOTHER 14. Maiden Name Dont Know

15. Birthplace Germany

16 (a) Informant Arthur Fink

(b) Address 2716 Guilford

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 26/45 (month) (day) (year)

(c) Cemetery or crematory Balto Cem

Location City

18 (a) Funeral director Ulrich Funeral Home

(b) Address 2108 Orleans St

19 DEC 26 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 23 1945, at 1:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 21 1945 to Dec 23 1945, and that I last saw h[illegible] alive on Dec 23 1945

Immediate cause of death Coronary Thrombosis — Duration probable one day

Due to Hypertensive cardio vascular Arteriosclerotic disease — Duration The hypertension was indefinite [illegible] of time

Other Conditions Benign Prostatic hypertrophy, acute urinary retention

(Include pregnancy within 3 months of death)

Date of operation NONE

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature O.W. Camponeschi M.D.

Address Church Home & Hosp Date signed 12/28/45

VS 180

O.W. CAMPONESCHI

G35547 — BALTIMORE CITY HEALTH DEPARTMENT — Registered No. G35547

CERTIFICATE OF DEATH

55 B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Redwood & Greene
(c) Hospital or institution: Univ. Hosp. 15
(d) Length of stay in hospital or inst. (yrs., mos., or days): 3
(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md (b) County:
(c) City or town: Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 1919 Wheeler ave
(If rural give location)
(e) Citizen of foreign country?: (Yes or No)
If yes, name country:

3 (a) FULL NAME: Mr Morris J. Goldstein

3 (b) If veteran, name war:

3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W	married

6 (b) Name of husband or wife: Fannie
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 1891

8. AGE: Years	Months	Days	If less than one day
54	10		hr. min.

9. Birthplace: Russia
(Town, county, and state)

10. Usual Occupation:

11. Industry or business: Merchant

FATHER
12. Name: Morris Golditch
13. Birthplace: Russia

MOTHER
14. Maiden Name: Bertha Stutman
15. Birthplace: Russia

16 (a) Informant: Henry Golditch
(b) Address: 1919 Wheeler Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Dec 26/45 (month) (day) (year)
(c) Cemetery or crematory: Hebrew Washington Blvd Cemetery
Location: Washington Blvd

18 (a) Funeral director: Sol Levinson & Bros.
(b) Address: 1124-26 W. North ave

19 (a) (b)
Registered by register: DEC 26 1945 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 25 1945, at 11:56 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/22 1945 to 12/25 1945, and that I last saw h[im] alive on 12/25 1945

Immediate cause of death: Respiratory failure — Duration:
Due to: Bronchial pneumonia
Due to: Chronic bronchitis and metastatic oncogenic sarcoma
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?: (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?: While at work?: (Specify type of place)
(e) Means of injury:

23. Signature: Richard O. Hoover M. D.
Address: Univ. Hosp. Date signed: 12/26

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35548

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G35548 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address [illegible]
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr
(e) Length of stay in Baltimore (yrs., mos., or days) 91 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. CHURCH HOME & HOSPITAL (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME LEAKIN, MARGARET

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 11 1852

8. AGE: Years 93 | Months 8 | Days 13 | If less than one day hr. min.

9. Birthplace MARYLAND (Town, county, and state)

10. Usual Occupation NONE

11. Industry or business NONE

FATHER
12. Name LEAKIN, DR. GEORGE
13. Birthplace MARYLAND

MOTHER
14. Maiden Name MILLER, ANNA
15. Birthplace DISTRIC OF COLUMBIA

16 (a) Informant SIOUSSAT, DR. ST. GEORGE
(b) Address LIBRARY OF CONGRESS

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 26/45 (month) (day) (year)
(c) Cemetery or crematory All Saints
Location Reisterstown Md

18 (a) Funeral director Henry W Parkins / Sons
(b) Address Mt Cullen Orchard Sts

19 (a) (Date rec'd by registrar) (b) Registrar

DEC 26 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/24 1945, at 1:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/9 1945 to 12/24 1945, and that I last saw HER alive on 12/23 1945.

Immediate cause of death [illegible] — Duration 8 hrs

Due to Congestive Heart Failure — 3 days

Due to Arteriosclerotic Heart Disease — ??

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: NO

of autopsy: NO

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address Church Home Hospital Date signed 12/24

X

G35549

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937 ✓ Registered No. G35549

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) Usu
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and name town)
(d) Street No. 215 N. Mount St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Wesley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: Col.
6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1890

8. AGE: Years 55 | Months | Days | If less than one day hr. min.

9. Birthplace Howard Co (Town, county, and state)

10. Usual Occupation Farm

11. Industry or business

FATHER
12. Name John Wesley
13. Birthplace Howard Co

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Charlotte Wesley
(b) Address Camp Misty Ft.

17 (a) Buried (Burial, cremation or removal) (b) Date thereof Dec 27 (month) (day) (year)

(c) Cemetery or crematory Woodlawn Cemetery
Location Howard Co

18 (a) Funeral director The H. C. Hunt Co
(b) Address Laurel Md

DEC 26 1945 (Date received by Registrar) Hunting for Williams Mgr Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 23 1945, at 6:10 P. M

21. I certify that I took charge of the remains described above, held an Inquest thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Roland Lee Graham M.D. (Medical Examiner.)
Date signed 12-24-45

VS 151

Please write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

G35550 BALTIMORE CITY HEALTH DEPARTMENT G35550

CERTIFICATE OF DEATH 92 B Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2022 Jefferson St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary E. Ellinghaus

3 (b) If veteran, name war —
3 (c) Social Security account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Paul

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-7-91

8. AGE: Years 54 | Months 2 | Days 17 | If less than one day hr. min.

9. Birthplace Harford Co. Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name George Carigan
13. Birthplace Ky.

MOTHER
14. Maiden Name Elizabeth Thelan
15. Birthplace O. ?

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 27/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto Md

18 (a) Funeral director Philip Henry Sons
(b) Address 2024 Orleans St.

19 (a) DEC 26 1945 Registrar
Huntington Williams, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH, Dec 24 19 45, at 11 30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 11 19 45 to Dec 24 19 45 and that I last saw her alive on Dec 24 19 45.

	Duration
Immediate cause of death: Cardiac failure	
Due to: Rheumatic heart disease & mitral stenosis	
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Graham A. Vance
Address Johns Hopkins Hosp. Date signed 12-27-45

PHYSICIAN
Underline the cause to which death should be charged statistically.

635551

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

176 Registered No. 635551

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Davison Chemical Co
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. ~~255 N. Howard St~~ 211 Pontiac Ave (If rural, give location)
(e) Citizen of foreign country (Yes or No)
If yes, name country

3 (a) FULL NAME Tilsbrin D. Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-07-0076

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mannie A Johnson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 5 1898

8. AGE: Years 47 | Months 7 | Days 19 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Crane Operator

11. Industry or business Davison Chemical Co

FATHER
12. Name Allonza Johnson
13. Birthplace Maryland

MOTHER
14. Maiden Name Nannie Robinson
15. Birthplace Maryland

16 (a) Informant Mrs Mannie A Johnson
(b) Address 211 Pontiac Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 27-45 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cemetery
Location Gor Ritchie Highway

18 (a) Funeral director Melton Schilling
(b) Address 3914 S. Hanover St

19 (a) (Date received by registrar) DEC 26 1945 (b) Huntington Hillen Registrar M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 24 1945, at 8:50 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushed Chest.

Due to

Other Conditions Fractured left arm and abrasions.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 2575
(a) Date of injury December 24 1945 A.M.
(b) Where did injury occur? Davison Chemical Co
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury Struck by Crane

23. Signature Robert A Foster M.D.
Medical Examiner.
Date signed 12-24-45

X

G35552 BALTIMORE CITY HEALTH DEPARTMENT ✓ G35552

CERTIFICATE OF DEATH 1639 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 24 E. Eager St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 24 E. Eager St (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Mildred M. Reynolds

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife: Thomas B. S. Reynolds

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 17, 1893

8. AGE: Years	Months	Days	If less than one day
51	2	7	hr. min.

9. Birthplace St. Peters, Minnesota (Town, county, and state)

10. Usual Occupation Registered Nurse

11. Industry or business

FATHER — 12. Name Dr. George W. MacIntyre

13. Birthplace Unknown

MOTHER — 14. Maiden Name Alma Felt

15. Birthplace Unknown

16 (a) Informant Dr. Mary Hodge

(b) Address 24 E. Eager Street

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 12-26-45 (month) (day) (year)

(c) Cemetery or crematory London Park

Location Frederick Avenue

18 (a) Funeral director John O. Mitchell & Son

(b) Address 198 Eutaw Place

19 (a) (b) Hunting for Williamsport, Md. Registrar

DEC 26 1945

US 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 24 1945, at 12 45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Codeine Poisoning.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Howard J. Mercer M.D. Medical Examiner.

Date signed 12-25-45

(Over)

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Use of abbreviations should be carefully supplied. Use

G35553

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G35553

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 813 Hollins St.
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 8
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 813 Hollins St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph. T Butajar, Sr

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Male
5. Color or race white
6 (a) Single, married, widowed, or divorced. Widower
6 (b) Name of husband or wife late Nellie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 5th 1850

8. AGE: Years 95 | Months 8 | Days 17 | If less than one day ... hr. ... min.

9. Birthplace London England
(Town, county, and state)

10. Usual Occupation
11. Industry or business Retired

FATHER
12. Name Joseph T. Butajar
13. Birthplace England

MOTHER
14. Maiden Name Unknown
15. Birthplace England.

16 (a) Informant Mrs Joseph. T Margaret
(b) Address 813 Hollins St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/26/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Ave

18 (a) Funeral director John J Bowan & Son
(b) Address 801-03 Hollins St

19 DEC 26 1945 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 22nd 1945 at 2 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 27 1945 to Dec 22 1945 and that I last saw h alive on Dec 22 1945.

Immediate cause of death Coronary Thrombosis — Duration 2 days
Due to —
Due to —
Other Conditions Arteriosclerosis — ?
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D.D. Kenyon M. D.
Address 336 Frederick Ave Date signed

G35554

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

106a

G35554 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 908 W. Lombard St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 908 W. Lombard St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary A. Biggin

3 (b) If veteran, name war ✓

3 (c) Social Security Account No.

4. Sex female | 5. Color or race white | 6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 21, 1871

8. AGE: Years 74 | Months 0 | Days 2 | If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation House work

11. Industry or business at Home

FATHER
12. Name John B. Biggin
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Catherine V. Phillips
15. Birthplace Baltimore Md

16 (a) Informant Mrs Harry A. Biggin
(b) Address 908 W Lombard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/28/45 (month) (day) (year)

(c) Cemetery or crematory New Cathedral Cem
Location 4300 Old Fed Road

18 (a) Funeral director John F Cowan Son
(b) Address 901-03 Collins Ave

DEC 26 1945 (Date received by registrar) Huntington Williams M.D. (Registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 23rd 1945 at 11:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5 Dec. 1945 to 23 Dec. 1945, and that I last saw her alive on 23 Dec. 1945

	Duration
Immediate cause of death Acute Cardiac Failure	5 Days
Due to Hypostatic Pneumonia	4 Days
Due to Acute Catarrhal Fever + Bronchitis	10 Days
Other Conditions Senescence.	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles Cummarata M.D.
Address 960 W. Lombard Date signed 24 Dec. 45 M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35555

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G35555

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1000 Darley Ave.
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1000 Darley Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mora M. White

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Martin J. White

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 28, 1878.

8. AGE: Years	Months	Days	If less than one day
66	11	24	hr. min.

9. Birthplace Ireland
(Town, county, and state)

10. Usual Occupation Home Duties

11. Industry or business

FATHER
12. Name John Cavanaugh
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Mannion
15. Birthplace Ireland

16 (a) Informant Mrs Catherine A. Gulliva
(b) Address 1000 Darley Ave.

17 (a) Burial (b) Date thereof 12/26/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore

18 (a) Funeral director Frederick A. Cole
(b) Address 1200 W. Lombard St

19 (a) (Date rec'd by registrar) (b) Registrar Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 22, 1945, at 7:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1944 to Dec 22 1945 and that I last saw her alive on Dec 22 1945

Immediate cause of death: Chronic Rheumatoid Arthritis
Bronchopneumonia

Duration: 30 years / one week

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Evl Smith M. D.

Address 1223 E. North Ave Date signed 12/27/45

G35556

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G35556 Registered No. 3698

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1206 Strieker St
(c) Hospital or institution: 16

(d) Length of stay in hospital or inst. (yrs., mos., or days) none
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1206 N Strieker St (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Geneva Markall

3 (b) If veteran, name war: No
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	married

6 (b) Name of husband or wife Roy Markall
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1901

8. AGE: Years	Months	Days	If less than one day
44	7	23	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business own home

FATHER
12. Name Wm. Thomas
13. Birthplace Md

MOTHER
14. Maiden Name Matilda Key
15. Birthplace Md

16 (a) Informant Roy Markall
(b) Address 1206 Strieker St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/27/45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. B. Kelso
(b) Address 1303 Pennsylvania Ave.

DEC 26 1945 Herrington Williams, M.D.
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 — 24 1945, at 3P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-23-1945, to 12-24-1945, and that I last saw her alive on 12-24 1945.

Immediate cause of death: Cerebral hemorrhage — Duration: 2 days
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Trump A. Saunders M. D.
Address 1029 N. Strieker St. Date signed 12-26-45

X

635557

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. 635557

Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly. USE WHITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1359 N Strucker St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1359 N Strucker St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James H. Walker

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4 Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Martha Walker

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 4, 1883

8. AGE: Years 62 | Months 8 | Days 18 | If less than one day: hr. min.

9. Birthplace Virginia (town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name George Walker

13. Birthplace Va

MOTHER 14. Maiden Name Unknown

15. Birthplace Unknown

16 (a) Informant Martha Thompson

(b) Address 2538 Dudley Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-27-45 (month) (day) (year)

(c) Cemetery or crematory Lancaster Co.

Location Va

18 (a) Funeral director George H. Kelson

(b) Address 1303 Pennsylvania Ave

(c) DEC 26 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 22 1945 at 3 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 4 1945 to Dec 22 1945 and that I last saw living on Dec 20 1945

Immediate cause of death: Pulmonary Edema — Duration

Due to: Chronic Myocarditis — Duration

Due to: Arteriosclerosis — Duration

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. B. Howell M. D.

Address 601 N Carrollton Ave Date signed 12/27/45

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

635558

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

47a

Registered No. 635558

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 833 - N. Caroline St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hettie Scott. (Hettie Prentow (Harris) Scott)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Black

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 29, 1888

8. AGE: Years 57 | Months | Days 23 | If less than one day hr. min.

9. Birthplace N. J.
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Plumas Harris.
13. Birthplace ?

MOTHER
14. Maiden Name Matilda Mathews
15. Birthplace ?

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (b) Date thereof 12/26/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Robert L. Crouch
(b) Address 864 N. Caroline St

19 (a) (b) Gilliams
(Signature and address) Huntington Ave.

DEC 26 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-22 1945, at 5 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-18 1945 to 12-22-1945 and that I last saw h alive on 12-22 1945

Immediate cause of death: Pneumonia — Duration

Due to: Cerebral Metastasis?

Due to: Carcinoma of Lung (Epithinal)

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Therapeutic Exploratory

of autopsy: Not Performed

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Loring W. Crouch M. D.
Address Johns Hopkins Hospital Date signed 12/26/45

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

635559 — BALTIMORE CITY HEALTH DEPARTMENT — 937 — 635559

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1437 E. Eager St
(c) Hospital or institution:
10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 18 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1437 E. Eager St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Armistead Nelson

3 (b) If veteran, name war None
3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Single.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years About 60 | Months | Days | If less than one day hr. min.

9. Birthplace Charles Town W. Va.
(Town, county, and state)

10. Usual Occupation Laborer (Unemployed)
11. Industry or business

FATHER
12. Name Henry Nelson
13. Birthplace Unknown

MOTHER
14. Maiden Name Dolly —
15. Birthplace Unknown

16 (a) Informant Sylvia D. Wilson Stephens
(b) Address 915 French St. Wilm. Del

17 (a) Shipment (b) Date thereof 12/27/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Charles Town W. Va.

18 (a) Funeral director Lohr F. Gourd
(b) Address Box A. Carlisle Pa.

19 (a) DEC 26 1945 (b) Wilmington, Delaware
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 24 1945 at 2:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 22 1945, to Dec 24 1945, and that I last saw her alive on Dec 24 1945.

Immediate cause of death Bronchopneumonia — Duration 2 days
Due to Myocarditis
Due to
Other Conditions Hypertension

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert L. Lefevre M. D.
Address 822 N. Bond Date signed 12/26/45

VS 150

635560

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92B

Registered No. G35560

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 345 S. Smallwood St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 65 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 345 S. Smallwood St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William A. Richter

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W.	Married

6 (b) Name of husband or wife. Elizabeth M. Richter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 26. 1877

8. AGE: Years	Months	Days	If less than one day
68	3	26	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Blue Print Dept.
11. Industry or business City of Baltimore

FATHER
12. Name Herman Richter
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Franke
15. Birthplace Germany

16 (a) Informant Mrs. Elizabeth M. Richter
(b) Address 345 S. Smallwood St.

17 (a) Burial (b) Date thereof Dec. 26. 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore, Md.

18 (a) Funeral director G. Howard Strong
(b) Address 3207 W. North Ave

19 DEC 26 1945 Huntington Williams, M.D.
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 24 1945, at 12:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1 1945 to Dec 24 1945 and that I last saw him alive on Dec 24 1945

Immediate cause of death Carcinoma of Colon — Duration

Due to Hypertension, Arteriosclerosis

Due to Cardiac Decompensation

Other Conditions Metastasis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Huntington Williams M. D.
Address 345 W. Mulberry Date signed Dec 24/45

VS 150

635561

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

635561 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2669 Pennsylvania Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2669 Pennsylvania Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNIE WATKINS

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife John D. Watkins
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 29, 1866

8. AGE: Years	Months	Days	If less than one day
79	8	24	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Emory E. Lee
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Collison
15. Birthplace Md.

16 (a) Informant Miss Frances Lee Watkins,
(b) Address 2669 Pennsylvania Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/26/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) DEC 26 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 23, 1945, at 10:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 22 1945 to Dec. 23 1945 and that I last saw her alive on Dec. 22 1945

Immediate cause of death

Chronic Myocarditis — Duration 5 Yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M.D.
Address Date signed 12/26/45

G35562

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G35562

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 606 N. Calvert St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William H. Otto

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Meta R. Otto

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 28, 1888

8. AGE: Years 57 | Months 0 | Days 24 25 | If less than one day hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation Bartender

11. Industry or business Marty Welsch

FATHER
12. Name William Otto
13. Birthplace Germany

MOTHER
14. Maiden Name -- Schroder
15. Birthplace Germany

16 (a) Informant Mr. William H. Otto
(b) Address White Marsh, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/27/45 (month) (day) (year)
(c) Cemetery or crematory St. Peter's Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) DEC 26 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 23 Dec 1945, 4:30 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William G. Hoffman M.D.
Medical Examiner.
Date signed 23 Dec 45

G35563

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G35563
Registered No.

CERTIFICATE OF DEATH 93D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison + Linden
(c) Hospital or institution: Maryland General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 713 C St. Sparrows Point
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret M. Llewellyn

3 (b) If veteran, name war: none
3 (c) Social Security Account No.:

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Hayden E. Llewellyn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Nov. 13, 1888

8. AGE: Years 57 | Months 1 | Days 11 | If less than one day hr. min.

9. Birthplace: Decatur, Ill.
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Dr. George Mezger
13. Birthplace: Germany

MOTHER
14. Maiden Name: Unknown
15. Birthplace:

16 (a) Informant: Mr. Haydon E. Llewellyn
(b) Address: 713 C St., Sparrows Pt.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/26/45 (month) (day) (year)

(c) Cemetery or crematory: Moreland Memorial Park
Location: Balto., Md.

18 (a) Funeral director: Wm. J. Tickner & Sons
(b) Address: Balto., Md.

DEC 26 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/24 1945 at 7 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/22 1945 to 12/24 1945 and that I last saw her alive on 12/24 1945.

	Duration
Immediate cause of death: [illegible]	
Due to: Cerebral Hemorrhage	2 days
Due to: Hypertension N. Disease	years
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Martin E. Strobel M. D.
Address Date signed

X

G35564

465556

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

Registered No. G35564

PLEASE WRITE PLAINLY, with UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) .....
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1510 Ruxdale St
(If rural give location)
(e) Citizen of foreign country? .....(Yes or No)
If yes, name country .....

3 (a) FULL NAME Elizabeth Brittain

3 (b) If veteran, name war .....
3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single.

6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 2-9-1879

8. AGE: Years	Months	Days	If less than one day
66	10	15	..... hr. ..... min.

9. Birthplace Pa
(Town, county, and state)
10. Usual Occupation Hand Embroidery work
11. Industry or business

FATHER
12. Name Joseph Brittain
13. Birthplace N.J.

MOTHER
14. Maiden Name Ada Flickstein
15. Birthplace Pa

16 (a) Informant Friends
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/27/45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn Md.

18 (a) Funeral director Wm. J. Tickner & Son
(b) Address Nat. Pa. Aves

19 (a) DEC 26 1945 (b) Huntington Williams, M.D.
(Date received by registrar) (Registrar)

MEDICAL CERTIFICATION A

20. DATE OF DEATH Dec. 24 1945 at 1205 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-21 1945 to 12-24 1945.
and that I last saw h[illegible] alive on 12-24 1945.

Immediate cause of death	Duration
Subdural Hemorrhage	
Due to	
Due to	
Other Conditions Metastatic Carcinoma of the breast	

(Include pregnancy within 3 months of death)

Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? .....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....
23. Signature D. A. Cooley
Address Johns Hopkins Hospital Date signed 12-26-45

VS 150

Please write the causes of death clearly and legibly. Correct age is especially important. Physicians: please write legibly and supply all items.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

635565 ✓ 635565 — 937 — Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 732 Hanover St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Kerell Kosanovet Carroll Kasanovich

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-26-9388

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
about 53			hr. min.

9. Birthplace Russian
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Not known
13. Birthplace Russian

MOTHER
14. Maiden Name Not known
15. Birthplace Russian

16 (a) Informant Mr. Mikaloyk
(b) Address 615 S. Charles St

17 (a) Burial (b) Date thereof Dec-26-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Trinity Russian
Location Stoney Run Md

18 (a) Funeral director John A. Grebinger
(b) Address 613 S. Paca St

DEC 26 1945 (b) Thomas J. Fitzgerald
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

DATE OF DEATH 12/22 19 45, at 11:25 P.M.

21. I certify that I took charge of the remains described above, held an Inspection-Inquiry thereon and from the evidence obtained
(Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Nature of injury

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 12/25/45

G35566

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 181

Registered No. G35566

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 425 W. Biddle
(c) Hospital or institution Balto. City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits write RURAL and give town)
(d) Street No. 425 W Biddle St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Boyd

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Married

6 (b) Name of husband or wife Louise

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1920

8. AGE: Years	Months	Days	If less than one day
25			hr. min.

9. Birthplace Columbus S. C.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name John Boyd
13. Birthplace Columbia S.C.

MOTHER
14. Maiden Name Beasie Glaze
15. Birthplace S.C.

16 (a) Informant Louise Boyd
(b) Address 426 N. Biddle St

17 (a) Burial (b) Date thereof Dec. 27, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. Geo. H. Hellam
(b) Address 1431 Druid Hill Ave
Hunting for Nellie

19 (a) DEC 26 1945 (b)
(Date received by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 21 Dec 1945, at 9:40 M

21. I certify that I took charge of the remains described above, held an ..... thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to ..... death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Uremia

Due to Second & third degree burns of both arms & both legs & face and thorax

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 9:35 AM 17 Dec '45
(b) Where did injury occur? Acme Oil Co
(c) Did injury occur at home, on farm, industrial place, in public place? 2nd floor While at work? Yes
(d) Means of injury Oil soaked clothing ignited

Signature William J. Helfrich M.D.
Medical Examiner.

Date signed 22 Dec 45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35269 311

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

✓ G35567 Registered No. 110a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 14
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1402 Hermindon Hill Ave
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Wm. McCoy

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Widower

6 (b) Name of husband or wife Emma
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Jan 27 77

8. AGE: Years	Months	Days	If less than one day
68	10	26	....hr. ....min.

9. Birthplace D. C.
(Town, county, and state)
10. Usual Occupation Chauffeur
11. Industry or business

FATHER
12. Name Richard McCoy
13. Birthplace ?

MOTHER
14. Maiden Name Kate ?
15. Birthplace ?

16 (a) Informant Friends.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Dec. 26, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Baltimore Co Md

18 (a) Funeral director Mrs. Louis H. Holland
(b) Address 1631 Druid Hill Ave.

19 (a)..... (b) Heather F. Williams, M.D.
(Date rec'd by registrar) Registrar

VS 15 DEC 26 1945

MEDICAL CERTIFICATION 50

20. DATE OF DEATH Dec. 22 1945 at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 20 1945 to Dec 22 1945 and that I last saw h[illegible] alive on Dec 22 1945

Immediate cause of death Empyema, right
Due to pleural cavity

Duration
9 weeks

Due to.....
Due to.....
Other Conditions.....
(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence.....at.....M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?.....While at work?.....
(Specify type of place)
(e) Means of injury.....

23. Signature A. Baird Hoffman, M.D.
Address Johns Hopkins Date signed 23 Dec

X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

171a

G35568 | Registered No. G35568

Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hosp. 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2111 Madison St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julia Brisco

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col.	Widowed

6 (b) Name of husband or wife Susan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years	Months	Days	If less than one day
75			hr. min.

9. Birthplace St. Mary's Co. Md.
(Town, county, and state)
10. Usual Occupation Waiter
11. Industry or business

FATHER
12. Name Robert Brisco
13. Birthplace Maryland

MOTHER
14. Maiden Name Eliza J. Brown
15. Birthplace Maryland

16 (a) Informant Mary Gaston
(b) Address 2111 Madison Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 27, 1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Cathedral
Location Baltimore, Md.

18 (a) Funeral director Geo. W. Hull & Son
(b) Address 1631 Druid Hill Ave.

19 (a) DEC 26 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 24 1945 at 10:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CUSTOM OF DEATH Atelectasis of Lungs; Cerebral Hemorrhage, right
Due to Fracture of right, left

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Dec. 14, 1945
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury Struck by streetcar

23. Signature Robert L. Kretzer M.D.
Medical Examiner.
Date signed 12-24-45

635569

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

635569 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dec
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2216 Muir St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Antoinette Hiekman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.)
8. AGE: Years 60 | Months | Days | If less than one day hr. min. 1485
9. Birthplace Ockley Iowa (Town, county and state)
10. Usual Occupation House keeper
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Wm Appler
(b) Address 2218 Muir St
17 (a) Burial (Burial, cremation or removal) (b) Date thereof Dec 26 1945 (month) (day) (year)
(c) Cemetery or crematory Baltimore Md
Location Baltimore Md
18 (a) Funeral director Leonard D. Covington
(b) Address 21 W. 25th St.
19 (a) DEC 26 1945 (Date rec'd by Registrar) Registrar Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 23 1945, at 1:15 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Ten Broeck M.D. (Medical Examiner.)
Date signed 12-24-45

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

635570

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registration No. 635570

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3022 E. Pratt st
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3022 E. Pratt st (If rural give location)
(e) Citizen of foreign country? yes (Yes or No)
If yes, name country Greece

3 (a) FULL NAME George Diacumakos

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widower

6 (b) Name of husband or wife Athena Diacumakos

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 18, 1866

8. AGE: Years	Months	Days	If less than one day
79	11	3	hr. min.

9. Birthplace Greece (Town, county, and state)

10. Usual Occupation Retired.

11. Industry or business

FATHER
12. Name Pete Diacumakos
13. Birthplace Greece

MOTHER
14. Maiden Name Athena Kokolis
15. Birthplace Greece

16 (a) Informant Mrs. Diacumakos
(b) Address 3022 E. Pratt St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 26 1945 (month) (day) (year)
(c) Cemetery or crematory Greek Orthodox
Location Baltimore Md.

18 (a) Funeral director Durward A. Carrington
(b) Address 21 W. 25th St.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150 DEC 26 1945 Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 21 1945, at 24 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1945 to Dec 21 1945 and that I last saw h alive on Dec 21 1945

Immediate cause of death	Duration
Myocardial degeneration	
Due to Arteriosclerotic heart disease	
Due to Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John J Gaul M. D.
Address 141 E. Fayette Ave Date signed 12-26-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35571

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G35571
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Raynor ave + Dukeland St
(c) Hospital or institution: West Balto General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4315 Roberts Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cecelia T. Boone

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Chas. E. Boone
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Aug 6-1913
8. AGE: Years 35 Months 4 Days 18 If less than one day hr. min.
9. Birthplace Balto Md (Town, county and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Gustav Wehe
13. Birthplace Balto Md

MOTHER
14. Maiden Name Louise Stegenhorst
15. Birthplace Balto Md

16 (a) Informant Mrs. John Hamilton
(b) Address 540 N. Dennison St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/27/45 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto Md
18 (a) Funeral director Geo E Boyce Sr
(b) Address 1512 Hollins St
19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 24 Dec 1945 at 7:42 PM
21. I certify that death occurred on the date above stated; that I attended deceased from 23 Dec 1945 to 24 Dec 1945 and that I last saw h alive on 24 Dec 1945

Immediate cause of death Respiratory failure — Duration
Due to Pulmonary Edema
Due to Pneumonia, lobar, R upper + middle lobes
Other Conditions Had left lower lobe

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy as indicated above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Luther A Hogle M. D.
Address 3 N. Balt. Med Bldg Signed 24 Dec

DEC 26 1945

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35572

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

G35572
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline & Oliver Sts.
(c) Hospital or institution:
St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 38 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6701 Greenland ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry E. Wells

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Margaret V. Walters
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/21/99.

8. AGE: Years	Months	Days	If less than one day
46	3	1	hr. min.

9. Birthplace Eastern Shore Md (Town, county, and state)
10. Usual Occupation Shipfitter
11. Industry or business Belt Transit Co

FATHER
12. Name Harry N.
13. Birthplace Eastern Shore Md

MOTHER
14. Maiden Name Bertha Brown
15. Birthplace Eastern Shore Md

16 (a) Informant Wife
(b) Address 6709 Greenland ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/26/45 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location 7225 Eastern ave

18 (a) Funeral director Clarence A. Hoffman
(b) Address 1639 N Broadway

19 (a) (Date rec'd by registrar) (b) Lexington & Williams, M.D. Registrar

DEC 26 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/22 1945 at 12:35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/15 1945 to 12/22 1945 and that I last saw h[illegible] alive on 12/22 1945

Immediate cause of death	Duration
Uremia -	
Due to Cardio-Renal Failure caused by Toxicity following	
Due to Partial Obstruction & Carcinoma of Rectum Sigmoid Junction	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 11/29/45; 12/11/45
Major findings of operation: Adenocarcinoma - Rectum - Sigmoid
of autopsy: Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address 5[illegible] Date signed 12/26/45

G35573 G35573

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4671 Park Heights Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4671 Park Heights Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Strauss
3 (b) If veteran, name war
(c) Social Security Account No.

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Adolph
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 1 1860

8. AGE: Years 85 | Months 4 | Days 23 | If less than one day hr. min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name George Durrbeck
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret ?
15. Birthplace Germany

16 (a) Informant Laura Manning
(b) Address 4671 Park Heights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/27/45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto Rd.

18 (a) Funeral director M. W. E. Oppel's Sons
(b) Address Lombard & Ann Sts.

19 (a) (Date rec'd by registrar) (b) Registrar's No.

DEC 26 1945 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 24 1945, at 4 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 15 1945 to Dec 24 1945 and that I last saw h[illegible] alive on Dec 4 1945.

Immediate cause of death Cerebral Hemorrhage — Duration 12/15/45

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John W. Burkert M.D.
Address 4805 Park Heights Ave Date signed 12/26/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

G35574

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1927

G35574 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 409 N. Kenwood Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) 63

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 409 N. Kenwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Schmitt (or) Rosalie Smith

3 (b) If veteran, name war: No.

3 (c) Social Security Account No.: None

4. Sex: F.

5. Color or race: W.

6 (a) Single, married, widowed, or divorced: Married.

6 (b) Name of husband or wife: Casper

6 (c) If alive, give age: 78 years

7. Birth date of deceased (mo., day, yr.): June 11 1872

8. AGE: Years 73 | Months 6 | Days 14 | If less than one day: hr. min.

9. Birthplace: Germany (Town, county, and state)

10. Usual Occupation: At Home

11. Industry or business:

FATHER
12. Name: August Schultz
13. Birthplace: Germany

MOTHER
14. Maiden Name: ?
15. Birthplace: Germany

16 (a) Informant: Casper Schmitt
(b) Address: 409 N. Kenwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/28/27 (month) (day) (year)
(c) Cemetery or crematory: Sacred Heart
Location: Gorman Ave

18 (a) Funeral director: M. W. E. Oppel & Sons
(b) Address: Howard & Lanvale Sts.

19 (a) Date received by Registrar: DEC 29 1927 (b) Registrar: Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 25 1927 at 3 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1927 to Dec 25 1927, and that I last saw her alive on Dec 25 1927.

Immediate cause of death: Cerebral Hemorrhage

Due to: Chr. Myocarditis + Endocarditis

Due to: Chr. Arteriosclerosis

Other Conditions: Carcinoma Rectum 2 yrs

Chr. Hypertrophied Prostate

(Include pregnancy within 3 months of death)

Duration: acute ? ? 2 yrs

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Mary Stengle

Address: 700 N. Gaith Date signed: 12/26/27

X

G35575

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V157E

G35575 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-5
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 416 S. Patterson Park
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Linda Radin or Linda Radin

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: F.
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife:
6 (c) If dead, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 6, 1945

8. AGE: Years | Months: 3 1/2 | Days: 19 | If less than one day: hr. min.

9. Birthplace: Balto.
(Town, county, and state)

10. Usual Occupation
11. Industry or business: None

FATHER
12. Name: John Radin
13. Birthplace: Va.

MOTHER
14. Maiden Name: Margaret Smith
15. Birthplace: Balto

16 (a) Informant: Mother
(b) Address: 416 S. Patterson Park

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 26 45 (month) (day) (year)
(c) Cemetery or crematory: Glen Haven
Location: Rutledge, Baltimore

18 (a) Funeral director: Matthew D. Pfeffle
(b) Address: 27 [illegible]

19 (a) DEC 26 1945 (Date rec'd by registrar) (b) Registrar's No. 11[illegible]

Huntington Wit[illegible]

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 25, 1945, at 3:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 6, 1945, to Dec. 25, 1945, and that I last saw her alive on Dec. 25 1945.

Immediate cause of death	Duration
Cardiac failure	
a pulm. edema	
Due to Congenital heart disease	
(Coronary thrombosis & interventricular septal defect)	
Due to	
Other Conditions Cloaca	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Congenital heart

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Albert J. Weiss
Address: Sinai Hospital Date signed 12/25/45 M. D.

X

G35576

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G35576

Type or print plainly with indelible pencil. Do not write above the lines. If the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Fleet St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 711 N. Barry St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harvey Shaffer

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Clara V. Shaffer
6 (c) If alive, give age 4 years

7. Birth date of deceased (mo., day, yr.) May 17, 1883

8. AGE: Years	Months	Days	If less than one day
62	7	7	hr. min.

9. Birthplace Carroll County, Md
(Town, county, and state)

10. Usual Occupation Gardener
11. Industry or business Self

FATHER
12. Name Levi Shaffer
13. Birthplace Md

MOTHER
14. Maiden Name — Reynold
15. Birthplace Md.

16 (a) Informant Maurice Shaffer
(b) Address 711 Berry St

17 (a) Burial (b) Date thereof 12/27/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St Paul Cemetery
Location Stulty, Md.

18 (a) Funeral director Howard N. Bligh Jr.
(b) Address 4914 Belair Road

19 (a) Filed DEC 26 1945 (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 24 1945, at 11:45 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage, apoplexy

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. Proctor M.D.
Medical Examiner.
Date signed 12-24-45

G35577

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G35577

Every item of information should be carefully supplied. The write the causes of death clearly and legibly. PRESS WHITE FIRMLY, WITH UNFADING INK. correct age is especially important. Physicians: please se

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1111 W. Lanvale St
(c) Hospital or institution: 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1111 W. Lanvale St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lucinda Carter
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Female
5. Color or race Colored
6 (a) Single, married, widowed, or divorced. Widow
6 (b) Name of husband or wife Richard Carter
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Mar 19, 1883
8. AGE: Years 62 Months 1 Days 3 If less than one day hr. min.
9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business
FATHER 12. Name Joseph Motley
13. Birthplace Va.
MOTHER 14. Maiden Name Mary Purse
15. Birthplace Va.
16 (a) Informant Mildred McNair
(b) Address 1614 Lorman St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 26 '45 (month) (day) (year)
(c) Cemetery or crematory Mt. Ambrose
Location
18 (a) Funeral director Mrs. K. R. Williams
(b) Address 322 N. Schroeder St.
DEC 26 1945 (Date rec'd by registrar)
(b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH December 22, 1945, at 4:30 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from June, 1945, to Dec., 1945, and that I last saw her alive on Dec 19, 1945.

Immediate cause of death Arteriosclerosis — Duration
Due to
Due to
Other Conditions Cardio-vascular disease
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature C. R. Campbell, M. D.
Address 718 Dolphin St. Date signed 12-26-45

VS 150

X

M. D. S. 1266-a

635578 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 635578

CERTIFICATE OF DEATH √50

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 9/0 Pierce Pl St., Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Venetta Henry Ryan

(a) Residence: No. 9/0 Pierce St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	Colored	married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Alfred Ryan

6. DATE OF BIRTH (month, day, year) April 15, 1902

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
43	8	7	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Same

10. Date deceased last worked at this occupation (month and year) ?

11. Total time (years) spent in this occupation 20 yrs

12. BIRTHPLACE (city or town) (State or country) Baltimore, Md

FATHER

13. NAME William Dyson

14. BIRTHPLACE (city or town) (State or country) Baltimore Maryland

MOTHER

15. MAIDEN NAME Ella Mattews

16. BIRTHPLACE (city or town) (State or country) Louisville, Kentucky

17. INFORMANT Miss Gertrude Ryan

(Address) 9/0 Pierce St

18. BURIAL, CREMATION, OR REMOVAL Burial

Place Mt. Auburn Date Dec. 26, 1945

19. UNDERTAKER Mrs. Katie R. Williams

(Address) 2 N. Schroeder St

DEC 26 1945

20. FILED Huntington Williams Asst

OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Dec. 22, 1945

22. I HEREBY CERTIFY, That I attended deceased from Sept 8, 1945 to Dec 22, 1945

I last saw her alive on Dec. 22, 1945 Death is said to have occurred on the date stated above, at 9:05 a.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Carcinoma of breast	2½ yrs
Other contributory causes of importance:	
General Carcinoma	4 mos.

Name of operation None Date of

What test confirmed diagnosis Physical Signs & Symptoms Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

No If so, specify

(Signed) John B. P. Camper M. D.

(Address) 639 N. Carey St, Balto, Md

G35579

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G35579

Please write clearly with pen and ink. Information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1512 S. Charles St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1512 S. Charles St.
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) **FULL NAME** Eleanor Joyce Rowan

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Infant

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec. 21, 1945

8. AGE: Years — | Months — | Days — | If less than one day 9 hr. — min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Infant

11. Industry or business —

FATHER 12. Name James N. Rowan

13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name Eva E. R. Kinehart

15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. D. Irene Rowan (Grand

(b) Address 1512 S. Charles St. Balto 30, Md

17 (a) Burial (b) Date thereof Dec. 22, 1945
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Baltimore, Md. Cem.

18 (a) Funeral director. J. Edward Evans

(b) Address 1400 S. Charles St. Balto 30, Md.

19 (a) Date registered DEC 26 1945 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 21, 1945, at 9:15 P.M.

21. I certify that death occurred on the date above stated; that attended deceased from 12/21/45 to 12/21/45 and that I last saw h[illegible] alive on Dec 21 1945

Immediate cause of death Prematurity — Duration 9 hrs

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

— of autopsy —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature [signature]

Address [illegible] Date signed 12/22/45

X

4/5

G35580

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G35580 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1613 N. Charles St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1613 N. Charles St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** John F. Carter
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	(widower)

6 (b) Name of husband or wife Catherine Carter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 17, 1854

8. AGE: Years	Months	Days	If less than one day
91 89	3	4	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Watchman
11. Industry or business Arundel Sand Co.

FATHER
12. Name John F. Carter
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Maria Sadler
15. Birthplace Balto. Md.

16 (a) Informant Mrs. An. Cohen
(b) Address 1613 N. Charles St.

17 (a) Burial (b) Date thereof Dec. 26 '45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd

18 (a) Funeral director Fred A. Kramer & Son
(b) Address 1216 N. Charles St

DEC 26 1945 Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. **DATE OF DEATH** Dec 21 1945, at 2.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 10 1945, to Dec 21 1945, and that I last saw him alive on Dec 20 1945.

Immediate cause of death	Duration
Myocardial Insufficiency	
Due to	
Due to	
Other conditions Arteriosclerosis & Myocarditis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation —
of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury

23. Signature John A. Schensul M. D.
Address 1339 N Charles St Date signed 12/22/45

X

635581

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 635581

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Balto
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Brooklawn
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELLIOTT, MARY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife James Elliott

(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years 69 Months Days If less than one day hr. min.

9. Birthplace Va
(Town, county, and state)

10. Usual Occupation Home wife

11. Industry or business

FATHER 12. Name William Wyatt

13. Birthplace Va.

MOTHER 14. Maiden Name Mildred Wyatt

15. Birthplace Va

16 (a) Informant Minnie Elliott

(b) Address Brooklawn Md

17 (a) (Burial, cremation, or removal) (b) Date thereof 12/29/45 (month) (day) (year)

(c) Cemetery or crematory Salem M. E. Cemetery

Location Upper Falls, Md

18 (a) Funeral director David Davidson

(b) Address Upper Falls Md

19 (a) Date received (b) Registrar Huntington Williams, M.D.

DEC 26 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 25 1945, at 9:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/15 1945 to 12/25 1945, and that I last saw h[illegible] alive on 12/25 1945.

Immediate cause of death Coronary occl. of heart with arteriosclerosis

Due to

Due to

Other Conditions hypertension, edema.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leonard Schultz M. D.

Address Sinai Hospital Date signed 12/26/45

PRINT WITH PENCIL, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35582 G35582

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1310

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 118 N. Mount St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days) 68 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(b) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 118 N. Mount St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosetta Nash.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female
5. Color or race Col.
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Henry Nash
6 (c) If alive, give age 74 years
7. Birth date of deceased (mo., day, yr.) 3/4/1877.
8. AGE: Years 68 Months 9 Days 14
If less than one day hr. min.
9. Birthplace Baltimore Md.
(Town, county and state)
10. Usual Occupation Domestic
11. Industry or business House Wife

FATHER
12. Name Moses Hughes
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Not Known
15. Birthplace Baltimore Md.

16 (a) Informant Herman Nash Son
(b) Address 118 N. Mount St.

17 (a) (Burial, cremation, or removal) (b) Date thereof 12 27 1945 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cem
Location Section D.

18 (a) Funeral director A. Jones
(b) Address 111 S. Gilmor st

(c) Date received by registrar Dec 26 1945 Registrar Washington Williams

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/23. 1945. at 10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 15. 1945 to 12/23. 1945. and that I last saw her alive on 12/23. 1945.

Immediate cause of death: Acute Myocarditis
Duration 4 hrs.
Due to Hypertension
Due to Interstitial Nephritis 4 mo.
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature L. A. T. Gunn M. D.
Address 526 N. Arlington Ave
Occupation Physician
L A T Gunn

G35583

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 107

G35583 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals ✓

(d) Length of stay in hospital or inst. (yrs., mos., or days) 54ays
(e) Length of stay in Baltimore (yrs., mos., or days) 72 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1904 Bank St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Fabiszak

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Henry (D)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Not Known

8. AGE: Years 74 Months 9 Days ? If less than one day ....hr. ....min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John
13. Birthplace Poland

MOTHER
14. Maiden Name ?
15. Birthplace Poland

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-29-45 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Balto. Co.

18 (a) Funeral director Wm. S. Fialkowski
(b) Address 2007 Eastern Ave

19 (a) (Day) (b) (Year) Huntington Ave. Baltimore, Md.

DEC 26 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 26 1945 at 5.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-21- 1945, to 12-26- 1945, and that I last saw her alive on 12-26 1945.

Immediate cause of death Bronchopneumonia — Duration ?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Margaret McDaniel M. D.
Address B.C.H. Date signed 12/26/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

635584

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

635584 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Street City
(c) Hospital or institution:
Little Sisters of the Poor 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 mos
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State ..... (b) County .....
(c) City or town .....
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME William Smith

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	widowed

6 (b) Name of husband or wife ?
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec 16, 1856

8. AGE: Years	Months	Days	If less than one day
89	0	9	..... hr. ..... min.

9. Birthplace Baltimore County Md.
(Town, county, and state)
10. Usual Occupation market dealer
11. Industry or business

FATHER
12. Name Joshua Smith
13. Birthplace Baltimore

MOTHER
14. Maiden Name Rosanna Ehrett
15. Birthplace Baltimore

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley Street City

17 (a) Burial (b) Date thereof Dec 29, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd

18 (a) Funeral director Harry A White
(b) Address 4101 Edmondson Ave.

19 (a) Date received Dec 26 1945 (b) Signature of Registrar Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec-25 1945, at 9 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1- 1945, to Dec 25 1945, and that I last saw him alive on Dec 25 - 1945

Immediate cause of death	Duration
Edema of Lungs	2 days
Due to Chronic Myocarditis	2 yrs
Due to	
Other Conditions Criteria - Sclerosis	5 yrs

(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? .....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....
23. Signature E Gill Hall
Address 1631 E. North ave Date signed Dec 26-45 M. D.

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35585

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G35585 Registered No. 83 B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 323 E 30 St
(c) Hospital or institution: 17
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 323 E 30 St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ellen J. Hunter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Del Hunter

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 11, 1873

8. AGE: Years 72 | Months 9 | Days 15 | If less than one day hr. min.

9. Birthplace Gloucester Co. Virginia
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Carter Braxton Williams

13. Birthplace Virginia

MOTHER 14. Maiden Name Alice Rebecca Dillman

15. Birthplace Virginia

16 (a) Informant Mrs Lucy Fitzhugh

(b) Address 323 E 30 St

17 (a) Removal (b) Date thereof Dec 26 1945
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Williams

Location Gloucester Co Virginia

18 (a) Funeral director Harry H Wiltshire

(b) Address 4101 Edmondson Ave

19 (a) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

DEC 26 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-26 1945, at 2 30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1943, to 12-26- 1945, and that I last saw h alive on 12-25 1945.

Immediate cause of death: cerebral Thrombosis — Duration: 2 days

Due to: arteriosclerosis

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert K Mortimer Jr

Address 7706 St Paul Date signed 12/26/45 M. D.

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

G35586

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G35586

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 804 Pontiac Ave
(c) Hospital or institution: 7 5th
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 804 Pontiac Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Abell McKay

3 (b) If veteran, name war — (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	widowed

6 (b) Name of husband or wife Julia Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 2nd 1860

8. AGE: Years	Months	Days	If less than one day
85	6	22	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation None
11. Industry or business None

MOTHER / FATHER
12. Name
13. Birthplace Mackown
14. Maiden Name
15. Birthplace

16 (a) Informant Mrs Edna Keil
(b) Address 808 Pontiac Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/27/45 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Annapolis Blvd

18 (a) Funeral director John T Kenny Inc
(b) Address 716 Light St.

(a) Date rec'd Dec 26 1945 (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 24 1945 at 7A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec-1 1945 to Dec-24 1945.
and that I last saw h/y alive on Dec-24 1945

Immediate cause of death Coronary Thrombosis — Duration 3 days.
Due to Arteriosclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Paul Latimer M. D.
Address 320 Outapoxline Date signed 12/26/45

VS 150

X

346319 G35587

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 134a

G35587 Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. The [illegible] number or information should be carefully supplied. Use

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 726 S Linwood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Tillie Gutowski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Anthony Gutowski

6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) 1900

8. AGE: Years 45 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Kowalewski
13. Birthplace Poland.

MOTHER
14. Maiden Name Katherine Katyros
15. Birthplace Poland

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 27/45 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Fred W. Ozazewski
(b) Address 1930 Eastern Ave.

19 (a) ..... (b) ..... (Filed by registrar) Registrar

26 1945

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 22 1945, at 6 P. M. 40

21. I certify that death occurred on the date above stated; that I attended deceased from 12-20- 1945, to 12-22 1945, and that I last saw her alive on 12-22- 1945.

Immediate cause of death	Duration
Due to Heart Failure	
Due to Renal Failure Uremia	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Renal Calculi

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Felix Rutledge M.D. M. D.

Address Johns Hopkins Hosp. Date signed 12/22/45

X

G35588

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 33a

G35588 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 828 Sharp St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 W
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 828 Sharp St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Abbie Turner

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/5/1888

8. AGE: Years 57 | Months 2 | Days 18 | If less than one day ..... hr. ..... min.

9. Birthplace Balto Md
(Town, county and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Lou Prout
13. Birthplace Md

MOTHER
14. Maiden Name Annie B. Turner
15. Birthplace Md

16 (a) Informant James Turner (B)
(b) Address 828 Sharp St

17 (a) Burial (b) Date thereof 12/26/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balto City

18 (a) Funeral director Isaiah L. Brown & Son
(b) Address 108 W Montgomery St

19 (a) Filed 12-26-1945 Registrar Huntington Williams M.D.

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/23 1945, at 9:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1945 to Dec 23 1945 and that I last saw h alive on Dec 23 1945

Immediate cause of death	Duration
Lobular Bronchopneumonia	10 days
Due to Influenza	13 days
Other conditions Nil	

(Include pregnancy within 3 months of death)
Date of operation Nil
Major findings of operation: —
of autopsy: Nil

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at — M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lindsley S. Felton
Address 905 S Sharp St Date signed 12-26-45

X

G35589

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 107

G35589 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard + Greene
(c) Hospital or institution: University Hospital 23
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 15 mo

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 907 Bolton (If rural give location) Hospital
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nellie M Lewson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 22-44

8. AGE: Years	Months	Days	If less than one day
1	15 3	2	hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Solo Gubbs
13. Birthplace Balto

MOTHER 14. Maiden Name Mary Lawson
15. Birthplace

16 (a) Informant Solo Gubbs
(b) Address 1001 Leadenhall

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-27-45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Ct
Location Balto Md

18 (a) Funeral director Isaac L Brown & Son
(b) Address 108 W Montgomery St

19 DEC 26 1945 (Date received by registrar) (b) Huntington for Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH December 24 1945, at 4:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-24, 19 to 19, and that I last saw h alive on 19.

Immediate cause of death: Confluent lobular Pneumonia, bilaterally.

Due to:

Due to:

Other Conditions: Spleen & Mesenteric lymphadenitis, ileus

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation: 0

of autopsy Confluent lobular Pneumonia

Duration

PHYSICIAN

Underline the cause to which death should be charged, statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature O. A. Wiswell M. D.
Address Univ. Hosp Date signed 12-24-45

VS 150

correct age is especially important. Physicians: please write the

635590

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 635590

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 810 Shuter St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 810 Shuter St
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Matilda Hebron.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Frederick Hebron

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 2nd 1870

8. AGE: Years 75 | Months 8 | Days 23 | If less than one day hr. min.

9. Birthplace Annapolis, Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Thomas Kimble
13. Birthplace Annapolis Md.

MOTHER
14. Maiden Name Eliza ?
15. Birthplace Annapolis Md.

16 (a) Informant Ethel Brown (daughter)
(b) Address 810 Shuter St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/28/45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Brooklyn

18 (a) Funeral director Mae Ola Bailey
(b) Address 1345 E. Jefferson St

DEC 26 1945
(Date rec'd by registrar) (b) Huntington Williams, Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 23 1945, at 6:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 19 1945, to Dec 23 1945, and that I last saw h alive on Dec 23 1945

Immediate cause of death Bronchopneumonia — Duration 1 day

Due to Myocarditis

Due to Nephritis

Other Conditions Hypertension

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert K. Lafont

Address 622 N. Bond St Date signed 12/28/45 M. D.

X

G35591

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

G35591 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette & John Streets
(c) Hospital or institution: Hospital for the Women of Maryland.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days) 20 days+

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Woodstock (If outside city or town limits, write RURAL and give town)
(d) Street No. ~~Woodstock~~ Hearwood St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Willetta Rausch.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, (Married), widowed, or divorced.
6 (b) Name of husband or wife: Joseph Rausch
6 (c) If alive, give age 57 years
7. Birth date of deceased (mo., day, yr.) Sept. 21, 1878
8. AGE: Years 67 | Months 3 | Days 1 | If less than one day ... hr. ... min.
9. Birthplace Carroll County, Maryland. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home-maker

FATHER
12. Name Sabert R. Trott
13. Birthplace Carroll Co, Maryland

MOTHER
14. Maiden Name Emily Phillips
15. Birthplace Carroll Co, Maryland

16 (a) Informant Deceased
(b) Address —

17 (a) Burial (burial, cremation, or removal) (b) Date thereof 12-26-45 (month) (day) (year)
(c) Cemetery or crematory Oakland Mills Cemetery
Location Oakland Mills, Md.
18 (a) Funeral director Loring Byers
(b) Address 5005 Park Heights Ave.
19 (a) DEC 26 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 22, 1945, at 10:50 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 3 1945 to Dec. 22 1945, and that I last saw her alive on Dec. 22 1945.

	Duration
Immediate cause of death Respiratory failure	
Due to Generalized carcinomatosis	
Due to Carcinoma of cervix	6 mos +
Other Conditions Jaundice & Cachexia	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy [redacted] permitted.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Donald F. Rays M. D.
Address Hospital for the Women of Maryland Date signed 12-26-45

X

corrections is especially important. Physicians: please write the causes of death clearly and legibly.

G35592

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

635592 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Arunah & Berkeland Ave.
(c) Hospital or institution: West Balto Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto, Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 2036 Mura St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ida K Fowler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Fe	W	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 4, 1880

8. AGE: Years	Months	Days	If less than one day
65	-	20	hr. min.

9. Birthplace Pa (Town, county, and state)

10. Usual Occupation House duties

11. Industry or business

FATHER
12. Name Tinkmann
13. Birthplace "

MOTHER
14. Maiden Name Tinkmann
15. Birthplace "

16 (a) Informant John O. Mitchell
(b) Address 1920 Eutaw Pl.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 27/45 (month) (day) (year)
(c) Cemetery or crematory St Johnstown
Location Greenmount Ave

18 (a) Funeral director John O. Mitchell & Son
(b) Address 1920 Eutaw Pl.

DEC 26 1945 (Date rec'd by Registrar) (b) Huntington Williams M.D. (Signature of Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 24 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 23 1945 to Dec 24 1945 and that I last saw h[illegible] alive on 24 DEC 1945.

Immediate cause of death	Duration
Congestive Failure	
Bilateral Bronchopneumonia	
Due to Auricular Fibrillation	
Arteriosclerotic Heart Dis	
Due to	
Other Conditions Cerebral Thrombosis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John O. Mitchell M. D.
Address U. S. P. Hosp Date signed 12/26/45

VS 150

correct age is especially important. Physicians: please write the

635593

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 64

635593 Registered No.

Use rubber stamps or death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto. General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dead
(e) Length of stay in Baltimore (yrs., mos., or days) 2 y

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 462 Boundview Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joanne Brown

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Col	

6 (b) Name of husband or wife 10-8-45

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/8/45

8. AGE: Years	Months	Days	If less than one day
X	3	17	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Wm D. Brown
13. Birthplace S. C.

MOTHER
14. Maiden Name Charlotte Fallon
15. Birthplace Penna.

16 (a) Informant William D Fallon
(b) Address 462 Boundview Rd.

17 (a) Burial (b) Date thereof 12-27-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Balto. City

18 (a) Funeral director Saml. W. Shadd Son
(b) Address 638 N. Gilmor St.

19 (a) [illegible] (b) Huntington Williams, Md.
Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 25 1945 at 3:55 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:
(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Pulmonary Edema

Due to

Other Conditions Enlargement of Thymus

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Dec. 26 1945

G35594

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G35594 Registered No. 1320

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1626 W. Saratoga St 12/25/45
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1626 W. Saratoga St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Myrtle West

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-8-1908

8. AGE: Years	Months	Days	If less than one day
37	9	16 17	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Edna Brown
(b) Address 1429 W. Franklin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-28-45 (month) (day) (year)
(c) Cemetery or crematory Arbutus
Location Balto. Co.

18 (a) Funeral director Samuel W. Chase & Son
(b) Address 638 N. Wilson St.

19 (a) (Date rec'd by Registrar) (b) Washington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/25 1945, 3:45 P M

21. I certify that I took charge of the remains described above, held an Inspection + Autopsy thereof and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Tbc

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] Medical Examiner M.D.
Date signed 12/26/45

635595

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 635595

Type or print in ink. Fill all items. Write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Providence Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1325 N. Carey St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Raymond Dorsey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years	Months	Days	If less than one day
63			hr. min.

9. Birthplace
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location University Medical School DEC 26 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) DEC 26 1945 (b) [signature] Registrar
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/16 1945, at 9:45 M

21. I certify that I took charge of the remains described above, held an Inspection-Inquest thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [signature] M.D.
Medical Examiner.
Date signed 12/26/45

5165

Please write clearly and legibly.

635596

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

9213

Registered 635596

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 400 Wilson Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 d. a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N. C. (b) County
(c) City or town Charlotte
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Theresa Greswell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1915

8. AGE: Years 30 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School

18 (a) Funeral director
(b) Address

19 (a) (Date rec'd by registrar) Registrar

DEC 26 1945
Commissioner of Health

MEDICAL CERTIFICATION

20. DATE OF DEATH December 18, 1945, at 5:40 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Mitral Stenosis.
Cardiac Decompensation.
Due to Rheumatic Endocarditis.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skotarelis M.D.
(Medical Examiner.)
Date signed December 18, 1945.

VS 151

5166

M. D. R. 1202-0

G3559? **HEALTH DEPARTMENT—CITY OF BALTIMORE**

CERTIFICATE OF DEATH ✓937 G3559?

1. PLACE OF DEATH

Registered No.....

CITY OF BALTIMORE: (No. 705 Beaumont St. or P. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred....yrs.....mos.....ds. How long in U. S. If of foreign birth?....yrs.....mos.....ds. 71

2. FULL NAME Emma Price

(a) Residence: No. 705 Beaumont St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Agustus H Price

6. DATE OF BIRTH (month, day, year) 10/13/1851

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
94	2	10	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Balto. Md

FATHER

13. NAME Joseph Armor

14. BIRTHPLACE (city or town) (State or country) unknown

MOTHER

15. MAIDEN NAME Rachel Seabery

16. BIRTHPLACE (city or town) (State or country) unknown

17. INFORMANT A R Price

(Address) 705 Beaumont

18. BURIAL, CREMATION, OR REMOVAL

Place Loudon Park Cem Date Dec 26 1945

19. UNDERTAKER A Bailey Slade

(Address) 4907 York Road

20. FILED DEC 26 1945 Harlington Williams, Registrar.

OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Dicmbr 23, 1945

22. I HEREBY CERTIFY, That I attended deceased from Dec 15, 1945 to Dec 23, 1945

I last saw h.m. alive on Dec 23, 1945 Death is said to have occurred on the date stated above, at 2.30 P.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
2 Chronic Myocarditis	1945
1 Arteriosclerosis	1944
Other contributory causes of importance: Senile dimentia	1945

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy?.....

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide?.....Date of injury....., 19....

Where did injury occur?.....

(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.....

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? No If so, specify.....

(Signed) J W. Bishop, M. D.

(Address) 501 Rhenda Ave

635598

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

635598 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ###
(c) Hospital or institution:
Maryland General Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 82 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (10)
(If outside city or town limits, write RURAL and give town)
(d) Street No. 106 Woodlawn Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME VIRGINIA LEE BOYD

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-12-4188

4. Sex F.

5. Color or race W.

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Clarence J. Boyd

6 (c) If alive, give age dec years

7. Birth date of deceased (mo., day, yr.) Jan. 7, 1864

8. AGE: Years 81 | Months 10 11 | Days 17 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Instructress- Dancing

11. Industry or business

FATHER
12. Name Elijah B. Royston
13. Birthplace Baltmore, Md

MOTHER
14. Maiden Name Virginia L. Sherwood
15. Birthplace Baltimore, Md.

16 (a) Informant Hugo K.L. Hurrelbrinck, Jr.
(b) Address 1519 Pentridge Rd. (12)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/27/45 (month) (day) (year)
(c) Cemetery or crematory Moreland Mem. Pk.
Location Taylor Avenue

18 (a) Funeral director Walter Brooks Bradley
(b) Address 1922 W. North Avenue (17)

19 (a) (Date rec'd by registrar) (b) Huntington-Williams Mort

DEC 26 1945

VS 100

MEDICAL CERTIFICATION A

20. DATE OF DEATH December 24 1945, at 1:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 22 1945, to Dec. 24 1945, and that I last saw her alive on Dec. 23 1945.

Immediate cause of death Hypostatic Pneumonia — Duration

Due to Arteriosclerotic C.V. Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Martin E. Strobel
Martin E. Strobel, MD
Address Md. Gen. Hospital Date signed 12/24/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Use only authorized abbreviations.

X

G35599

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 10

G35599 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland ✓
(b) Street address
(c) Hospital or institution: Sydenham Hospital, Baltimore 5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) 6 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1416 E. Baltimore St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Doris M. Ours

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1928

8. AGE: Years	Months	Days	If less than one day
17			hr. min.

9. Birthplace Detroit, Mich.
(Town, county, and state)
10. Usual Occupation House keeper
11. Industry or business —

FATHER
12. Name Adam Ours
13. Birthplace W Va

MOTHER
14. Maiden Name Lillian Dahl
15. Birthplace Detroit Mich

16 (a) Informant Treva Swick (sister of deceased)
(b) Address Baltimore Tel. Wo 1190

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/29/45 (month) (day) (year)
(c) Cemetery or crematory Petersburg
Location Petersburg W Va

18 (a) Funeral director Fallhom Bros Inc
(b) Address 1219 E Fort Ave

12 26 1945 (b) Huntington W. Virginia
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 24 1945 at 9:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-13 1945 to 12-24 1945 and that I last saw h. alive on 12-24 1945

Immediate cause of death: Acute Cardiac Dilatation — Duration

Due to: Diphtheritic Myocarditis

Due to: Diphtheria, tracheo-bronchial

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 12-13-45

Major findings of operation: Tracheo-bronchial Diphtheria

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Methuiah Sprague
Address Sydenham Hosp. Date signed 12-24-45

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Use

VS 150

G35600

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

167

G35600

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto. Gen'l. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N.C. (b) County
(c) City or town Highpoint (If outside city or town limits, write RURAL and give town)
(d) Street No. 105 Highland Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Dallas R. Long

3 (b) If veteran, name war: W. W. #2

3 (c) Social Security Account No. 241-18-7817

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Louise Walton

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/23/21 1921

8. AGE: Years 24 | Months 8 | Days 3 | If less than one day hr. min.

9. Birthplace: High Point, N. C. (Town, county, and state)

10. Usual Occupation

11. Industry or business: Merchant Marine

FATHER
12. Name: W. E. Long
13. Birthplace: Va.

MOTHER
14. Maiden Name: Emily King
15. Birthplace: N. C.

16 (a) Informant: Mrs. Louise W. Long
(b) Address: High Point, N. C.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 12/27/45 (month) (day) (year)
(c) Cemetery or crematory: Primitive Bapt. Church
Location: Highpoint N. C.

18 (a) Funeral director: Wilson Funeral Home
(b) Address: 1217 Ft. Ave. Ft.

19 (a) DEC 26 1945 (Date received by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 25- 1945, at 4:35 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to Its death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Stab wound of pulmonary artery & L lung.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12/25/45 at 4:20 A M.
(b) Where did injury occur? Aboard S.S. George A. Cirley - Pier 7
(c) Did injury occur at home, on farm, industrial place, in public place? Ship board: While at work? Yes
(d) Means of injury Stabbed Assailant

23. Signature Thomas J. Cholakis M.D. Medical Examiner.
Date signed 12-26-45

VS 151

(Over)

G35601

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G35601 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1018 W. Baltimore St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Thiess John C. Thiess

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Laura Thiess
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 28, 1870

8. AGE: Years	Months	Days	If less than one day
75	10	27	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Retired Police Officer
11. Industry or business City of Baltimore

FATHER
12. Name Mr. Thiess
13. Birthplace United States

MOTHER
14. Maiden Name Unknown
15. Birthplace United States

16 (a) Informant Mr. Frank J. Thiess
(b) Address 8202 Queen Anne Dr., Silver Spring Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 28, 1945 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Baltimore, Md.

18 (a) Funeral director Willis Undertaking Co.
(b) Address 1069 W. Baltimore St.

19 (a) Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/25 1945, at 2:25 P.M.

21. I certify that I took charge of the remains described above, held an Inspection-Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C.V disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. J. Pelouze M.D.
Medical Examiner.
Date signed 12/26/45

C 2 VR 1945

G35602

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G35602
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4615 Park Heights Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3901 Barrington Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mollie Gershenson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Late Peisach
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1852

8. AGE: Years	Months	Days	If less than one day
93			hr. min.

9. Birthplace Russia
(Town, county, and state)
10. Usual Occupation
11. Industry or business None

FATHER
12. Name Max Biller
13. Birthplace Russia

MOTHER
14. Maiden Name Chana ?
15. Birthplace Russia

16 (a) Informant Max Gershenson
(b) Address 3901 Barrington Road

17 (a) Burial (b) Date thereof Dece,ber 27, 1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Herring Run Cem
Location Bowleys Lane

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 N North Ave

26 1945 (a) Huntington Williams, M.D. (b)
(Filed by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 26 1945 at 8.45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/14 1945 to 12/24 1945
and that I last saw h[illegible] alive on 12/24 1945.

Immediate cause of death	Duration
Acute Bronchopneumonia	
Due to	
Due to Cardiac Weakness	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence 1945 at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature [illegible]
Address 733 Longwood St Date signed 12/26/45 M. D.

X

correct age is especially important. Physicians: please write

VS 150

G35603

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V48a

G35603 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3'
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 911 Whitelock St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Herman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex White Female

5. Color or race

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-23-98

8. AGE: Years 47 | Months 4 | Days 3 | If less than one day hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Kalman Hornstein
13. Birthplace Md

MOTHER
14. Maiden Name Cecelia ?
15. Birthplace Germany

16 (a) Informant Record
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Dec 27/45
(Burial, cremation, or removal) (month) (day), (year)
(c) Cemetery or crematory Hebrew Friendship
Location 3600 E. Balto st

18 (a) Funeral director Sol Levinson & Bros.
(b) Address 1124-26 W. North ave

19 (a) DEC 26 1945 (b)
(Date rec'd by registrar) Registrar

Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 26 1945 at 9 15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1945 to Dec 26 1945 and that I last saw her alive on Dec 26 1945

Immediate cause of death	Duration
Shock, Internal hemorrhage	
Due to Carcinoma of cervix	2 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. D. Kelly

Address Johns Hopkins Hosp. Date signed 12/26/45 M. D.

VS 150

correct age is especially important. Physicians: please write the

G35604

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G35604
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Charles
(c) City or town Bel Alton
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Audrey Butler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Black | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-26-43

8. AGE: Years 2 | Months 11 | Days 4 | If less than one day hr. min.

9. Birthplace Md (Town, county and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name John Butler
13. Birthplace Md

MOTHER
14. Maiden Name Elizabeth Queen
15. Birthplace Md

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/28/45 (month) (day) (year)
(c) Cemetery or crematory St. Ignatius
Location Bel Alton, Md

18 (a) Funeral director Hunt & Ryon
(b) Address Waldorf, Md.

19 DEC 26 1945 (Date rec'd by registrar) Huntingtown, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 24 1945 at 5 1/2 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 11 1945 to Dec 24 1945 and that I last saw h[illegible] alive on Dec 24 1945

Immediate cause of death	Duration
Respiratory Failure	
Due to Aspiration pneumonia	
Due to Encephalitis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Blair E. Batson M. D.
Assistant Resident
Address Johns Hopkins Hospital Date signed 12/26/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G35605

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G35605

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution:
Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2d 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1603 St. Paul St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence [illegible] Bateman

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-01-9208

4. Sex	5. Color or race	6 (a) ~~Single, married, widowed~~, or divorced.
M	W	Divorced

6 (b) Name of ~~husband or wife~~ Unknown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 2nd 1892

8. AGE: Years	Months	Days	If less than one day
53	5	13	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business Pike Fishing

FATHER
12. Name Samuel B. Bateman
13. Birthplace Va

MOTHER
14. Maiden Name Margaret O'Leary
15. Birthplace Md.

16 (a) Informant Samuel J. Bateman (Brother)
(b) Address 1504 E. Federal St.

17 (a) Burial (b) Date thereof 12/29/45
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) DEC 27 1945 (b) Huntington for Williams
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/26 1945 at 11 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy-Inquest thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 12/26/45

635606

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

635606 Registered No.

Please write the causes of death clearly and legibly. The correct age is especially important. Physicians: please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4817 Forrest Park Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4817 Forrest Park Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wilmer L. Chrystal

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-05-9170

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug 29th 1888

8. AGE: Years	Months	Days	If less than one day
57	3	27	hr. min.

9. Birthplace Balto. Md. (town, county, and state)
10. Usual Occupation Electrician
11. Industry or business St. Lighting Co.

FATHER
12. Name Daniel I. Chrystal
13. Birthplace Md.

MOTHER
14. Maiden Name Laura V. Miles
15. Birthplace Md.

16 (a) Informant John C. Chrystal
(b) Address 4817 Forrest Park Ave

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 12/29/45 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Balto. Co. Md.

18 (a) Funeral director William Cook Inc
(b) Address 217 St. Paul St

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 26th 1945 at 8 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1945 to Dec 26 1945, and that I last saw h alive on Dec 25 1945

Immediate cause of death Coronary Thrombosis — Duration 24 hrs

Due to Hypertension Cardiovascular Disease — 5 yrs

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John T Rhrt M. D.
Address 4509 Liberty Heights Ave Date signed 12-26

G35607

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83D

Registered No. G35607

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Use no abbreviations. Necessary supplies. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2109 W Fayette St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2109 W Fayette St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lucy Barnes (Barnas)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W	Widowed

6 (b) Name of husband or wife William
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1871

8. AGE: Years	Months	Days	If less than one day
74			hr. min.

9. Birthplace Poland
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Fred. Vanderbeck
(b) Address 2109 W Fayette St.

17 (a) Burial (b) Date thereof Dec 27-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Belair Rd

18 (a) Funeral director Joseph Kaminskas Sons
(b) Address 602 Wash. Blvd

(b) (Signature of local registrar) Handling for Williams & Co
DEC 27 1945 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 23 — 1945, at 4 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 20 1945, to Dec 23 1945; and that I last saw h[illegible] alive on Dec 23 1945.

Immediate cause of death
Pulmonary Oedema
Due to Hypertension
Due to Arteriosclerosis
Other Conditions Senility
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(d) Means of injury

23. Signature Dr. Frank C. Yutzy M. D.
Address 215 Wickham Av Date signed 12/24/45

G35608

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

+ ✓ 55E

G35608 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State W Va (b) County
(c) City or town Beckley
(If outside city or town limits, write RURAL and give town)
(d) Street No. Rt. #1 Box 216
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Arch Thompson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-16-40

8. AGE: Years	Months	Days	If less than one day
5	8	10	hr. min.

9. Birthplace W. Va. (Town, county, and state)
10. Usual Occupation Child
11. Industry or business

FATHER 12. Name Harold Thompson
13. Birthplace Lee

MOTHER 14. Maiden Name Delphia Lively
15. Birthplace W. Va.

16 (a) Informant Records Johns Hopkins Hospital
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof 12/27/45 (month) (day) (year)
(c) Cemetery or crematory Beckley, W. Va.
Location

18 (a) Funeral director John D. Critchfield & Sons
(b) Address 1405 Eutaw Place

19 (a) (Signature of Registrar) (b) Registrar
DEC 27 1945
Huntington, West Virginia

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 26 1945 at 12 00 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 17 1945 to Dec. 26 1945 and that I last saw h alive on Dec 26 1945

Immediate cause of death: Lymphosarcoma
Due to: Chronic Tonsillitis — Duration: 6 mo.
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Warren O. Quinlan M. D.
Address Johns Hopkins Hospital signed 12-26-45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35609

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51B

G35609 Registered No.

Physicians: please write the correct age is especially important. The accuracy of information depends on certainty supplied. Use the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 412 E. Cross St.
(c) Hospital or institution:
24
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 416 E. Cross St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank E. Hackett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	widower

6 (b) Name of husband or wife Margaret
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 24, 1871

8. AGE: Years	Months	Days	If less than one day
73 74	11	29	hr. min.

9. Birthplace New Jersey (Town, county, and state)
10. Usual Occupation Engineer
11. Industry or business Balto City

FATHER
12. Name John H. Hackett
13. Birthplace N.J.

MOTHER
14. Maiden Name Martha E. Venable
15. Birthplace N. J.

16 (a) Informant Martha E. Hutchinson
(b) Address 412 E. Cross St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/27/45 (month) (day) (year)
(c) Cemetery or crematory Schwartz Cem.
Location O'Donnell St.

18 (a) Funeral director John F. Denny Inc
(b) Address 716 Light St.

19 (a) (b)
Date received by registrar DEC 27 1945 Registrar Huntington Woodward, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 23rd 1945; at M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/9/ 1944 to 12/23 1945 and that I last saw him alive on 12/23/ 1945

Immediate cause of death Malignancy of prostate with general metastasis — Duration 2

Due to —

Due to —

Other Conditions none

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry Deiler

Address 1216 Hanover St. Date signed 12/26/45 M. D.

G35610

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No. G35610

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3616 Ninth St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 Y
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3616 Ninth St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Edith M. Root

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Arthur D.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): unknown

8. AGE: Years: abt. 70 | Months | Days | If less than one day: hr. min.

9. Birthplace: New York
(Town, county, and state)

10. Usual Occupation: None

11. Industry or business: None

FATHER
12. Name: Wm Vandenburgh
13. Birthplace: New York State

MOTHER
14. Maiden Name: Susan Kelly
15. Birthplace: New York State

16 (a) Informant: Mean D. Root
(b) Address: 3616 Ninth St.

17 (a) Entombment (Burial, cremation, or removal) (b) Date thereof 12/27/45 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: Frederick Ave

18 (a) Funeral director: John F. Dennis Inc
(b) Address: 24 Light St.

19 (a) (Date rec'd by registrar) (b) Registrar

DEC 27 1945 Harding for Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 24 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/10 1945 to 12/24/1945 and that I last saw h 62 alive on 12/24 1945.

Immediate cause of death: Hypertensive cardio vascular nephritic disease. — Duration: 2

Due to —

Other Conditions. —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry Deibel M. D.

Address 1226 Hanover St. Date signed 12/26/45

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35611

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G35611

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution:
SINAI HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4009 Gent. Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Mandell

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	married

6 (b) Name of husband or wife Betty
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1912

8. AGE: Years	Months	Days	If less than one day
33			hr. min.

9. Birthplace Wash. D.C. (Town, county, and state)
10. Usual Occupation Jeweler
11. Industry or business

FATHER
12. Name Abe Mandell
13. Birthplace Russia

MOTHER
14. Maiden Name Rebecca Aaronson
15. Birthplace Russia

16 (a) Informant Hosp Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-27-45 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location Hermon Hill Rd

18 (a) Funeral director Jacob Lewis Inc
(b) Address 1439 E. Baltimore St.

19 (a) DEC 27 1945 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-25 1945, at 6.00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-29 1945 to 12-25 1945, and that I last saw h[illegible] alive on 12-25 1945

Immediate cause of death: Malignant nephrosclerosis & Hyp. CARDIOVASC DISEASE — Duration 2+ years
Due to: card. dil + Hyp. mitral insuff — 2 years
Due to: marked congestive failure uremia — 1 month ?
Other Conditions: pleurisy

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation —
of autopsy: Above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Kenneth Katz
Address Sinai Hosp Baltimore Md Date signed 12-25-45

correct age is especially important. Physicians: please write

G35612

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

Registration No. G35612

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4001 Cottage Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 4001 Cottage Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Arnold Jeny Kermisch

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 15, 1940

8. AGE: Years	Months	Days	If less than one day
	8	11	hr. min.

9. Birthplace Balto Md
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Howard Kermisch
13. Birthplace Balto

MOTHER
14. Maiden Name Gertrude
15. Birthplace Balto

16 (a) Informant Howard Kermisch
(b) Address 4001 Cottage Ave

17 (a) Burial (b) Date thereof 12-27-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Phil Rd & Hamilton Ave

18 (a) Funeral director Parks Funeral Home
(b) Address 1439 E. Balto St

19 (a) DEC 27 1945 Huntington Williams M.D.
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/26/45, 19, at 1P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 15, 1945 to Dec 26, 1945 and that I last saw h[illegible] alive on Dec 23, 1945

Immediate cause of death: Acute Lymphatic Leukemia — Duration: 2 months
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John A. Aston M.D.
Address 2306 Parkview Date signed 12/26/45 M. D.

VS 150

G35613

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

Registered No. G35613

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Mt B Gen. Hosp.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) life
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 508 S. Lakewood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Irving J. Pearman

3 (b) If veteran, name war: W.W. II
3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife: Laura Pearman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 24, 1908

8. AGE: Years 37 | Months 2 | Days 28 | If less than one day: hr. min.

9. Birthplace: Balto Md.
(Town, county, and state)

10. Usual Occupation: Truck Driver

11. Industry or business

FATHER
12. Name: Chas B. Pearman
13. Birthplace: Balto

MOTHER
14. Maiden Name: Anna Frederick
15. Birthplace: Balto

16 (a) Informant: Laura Pearman
(b) Address: 508 S Lakewood

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 27 (month) (day) (year)
(c) Cemetery or crematory: Balto Nat Cem
Location: Rural

18 (a) Funeral director: Ulrich Funeral Home
(b) Address: 2005 Pulaski St

19 (a) DEC 27 1945 (Date rec'd by registrar) Huntington Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-22-1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-22-1945, to 12-22-1945, and that I last saw h.im. alive on 12-22-1945.

Immediate cause of death	Duration
Acute Lymphatic Leukemia	2 wks(?)
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of op[illegible]
Major findi[illegible] operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, s[illegible]de, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Daniel Ehrlich M. D.
Address 1213 Light St. Date signed 12-22-45

G35614 74953

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G35614 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write carefully and correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 -5-9days
(e) Length of stay in Baltimore (yrs., mos., or days) 69 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 406 N. Collington Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Harold Boggs

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 22nd.1873

8. AGE: Years	Months	Days	If less than one day
72	1 8	8 1	hr. min.

9. Birthplace Washington D.C
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Robert Wadsworth
13. Birthplace Va.

MOTHER
14. Maiden Name Belle Virginia Chase
15. Birthplace Me.

16 (a) Informant Baltimore City Hospitals
(b) Address Record Room 4940 Eastern Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/27/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto

18 (a) Funeral director Welsh Funeral Home
(b) Address 2008 Orleans St

19 (a) DEC 27 1945 (Date rec'd by registrar) Huntington W. Jones, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 23rd, 19 45 at 12.15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 26th 19 45 to L2-23-45 19, and that I last saw him alive on Dec. 23rd 19 45.

Immediate cause of death	Duration
Carcinoma of Sigmoid bowel &	?
Metastases	
Due to	
Due to	
Other Conditions diabetes mellitus	?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Carcinoma of

of autopsy: Metastases

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E J Penny MD M. D.
Address BCH Date signed 12/26/45

VS 150

G35615

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G35615

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 240 N.Rose St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) b'
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 240 N.Rose St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna B.Burkman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife: Frederick A.Burkman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov.1-1882

8. AGE: Years	Months	Days	If less than one day
63	1	23	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name John Geisler
13. Birthplace Germany

MOTHER
14. Maiden Name Not Known
15. Birthplace Not Known

16 (a) Informant Frederick A.Burkman
(b) Address 240 N.Rose St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec.27-45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn.Cem.
Location Woodlawn,Md.

18 (a) Funeral director John A.Miller
(b) Address 2334 Jefferson St.

19 DEC 27 1945 (Date rec'd by Reg.) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 24 1945, at 5 20 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 17 1945 to Dec 24 1945 and that I last saw h alive on Dec 23 1945

Immediate cause of death Coronary Thrombosis — Duration 1 wk.

Due to arterio-Sclerosis — Duration —

Due to cardio-vascular Renal Dis — Duration —

Due to — Duration

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis F. Krumrine M. D.
Address 722 N. Howard Date signed 12-26-45

correct age is especially important. Physicians: please write the

G35616
AB-97828

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

12B

G35616
Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940m Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or, town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 525 Washington Blvd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elmer (Dodges) Daukszis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Separated

6 (b) Name of husband or wife Ida
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 8- 1913

8. AGE: Years	Months	Days	If less than one day
32	11	17	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Andrew Daukszis (D)
13. Birthplace Russia

MOTHER
14. Maiden Name Victoria Duker
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals(Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof Dec 28-1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location
18 (a) Funeral director Edward A. Toulson
(b) Address 7359 Washington Blvd
19 Dec 27 1945 (b) Huntington Williamsport M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 25- 19 45, at 12.15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-16 19 45 to 12-25 19 45, and that I last saw h im alive on 12-25 19 45

Immediate cause of death Hypertension causing Stroke

Due to Duodenal Ulcer

Due to

Other Conditions Pulmonary Tuberculosis for advanced

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Samuel

Duration
2

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert B Copeland Jr M.D.
Address Balt. City Hosp. Date signed 12/26/45

1178

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

G35617

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G35617

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2213 Mt. Holly St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2213 Mt. Holly St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN LESLIE CARD

3 (b) If veteran, name war	3 (c) Social Security Account No.
Spanish American War	217-01-3429

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Jessie I. Coleman Card
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 22, 1882

8. AGE: Years	Months	Days	If less than one day
63	8	3	hr. min.

9. Birthplace Bangor, Maine
(Town, county, and state)
10. Usual Occupation Designing Engineer
11. Industry or business Becker Pretzel Co.

FATHER
12. Name Joseph B. Card
13. Birthplace Maine

MOTHER
14. Maiden Name Edith Frost
15. Birthplace Maine

16 (a) Informant Mrs. Ruth Wood
(b) Address 203 Tunbridge Rd.

17 (a) Removal (b) Date thereof 12/27/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Oxford Cem.
Location New Oxford, Pa.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) DEC 27 1945 (b) Huntington Wilkerson, M.D. Registrar
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 25, 1945, at 2:20A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1945 to Dec 25 1945.
and that I last saw him alive on Dec 24 1945.

Immediate cause of death	Duration
Respiratory failure	
Due to Sarcoma intestinal ???	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Shorofsky M.D.
Address 601 N. Monroe St Date signed 12/26/45

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35618

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

830 ✓

Registered No. G35618

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 820 Bradley Av (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Tony Rose

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	—

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years	Months	Days	If less than one day
49			hr. min.

9. Birthplace — (Town, county, and state)
10. Usual Occupation Day Laborer
11. Industry or business

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Marion Watkins
(b) Address 819 Fountain

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 29 45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director James Stamper
(b) Address 1422 W. Fayette St

19 (a) DEC 27 1945 (Date received by local registrar) (b) Huntington Hillsdale Md Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 25 1945, at 8:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 20 1945, to Dec 25 1945. and that I last saw him alive on Dec 25 1945.

Immediate cause of death Cerebral Hemorrhage — Duration 5 days
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry E. Wheeler
Address Saint Bolls. Jon. Date signed 12-25-45 M.D.

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35619

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G35619 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Southern Hospital
(c) Hospital or institution: 2510 Greenmount Ave.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2845 Huntington Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Fannie M. Standiford

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife F. Standiford
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 14, 1867

8. AGE: Years	Months	Days	If less than one day
78	7	10	hr. min.

9. Birthplace Baltimore County, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Dennis Rosier
13. Birthplace ?

MOTHER
14. Maiden Name Cathrine Brough
15. Birthplace ?

16 (a) Informant Lillian Knight
(b) Address 2433 Barclay St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/27/45 (month) (day) (year)
(c) Cemetery or crematory New
Location New Market, Md.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1500 Eutaw Place

DEC 27 1945 (Date received by registrar) Justin for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 24 19 45, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1935, to Dec. 24 1945, and that I last saw her alive on Dec. 21 1945.

Immediate cause of death	Duration
Cerebral Hemorrhage	1 wk.
Due to Arteriosclerotic Cardio-Vascular Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. Weinzapfel M. D.
Address 1927 E. North Ave. Date signed

VS 150

035620

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No. 035620

Please write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address JOHNS HOPKINS HOSPITAL
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Harford
(c) City or town Bel Air
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice Jackson
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Black | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife J. Clay Jackson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10 - 3 - 81

8. AGE: Years 64 | Months 2 | Days | If less than one day ... hr. ... min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Edward Williams
13. Birthplace Md.

MOTHER 14. Maiden Name Katherine Collins
15. Birthplace Md

16 (a) Informant [redacted]
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 28-1945 (month) (day) (year)
(c) Cemetery or crematory Clark Chapel
Location Near Darlington, Harford Co.

18 (a) Funeral director Henry Jarrett Haines
(b) Address DEC 27 1945 Aberdeen Md.

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 26 1945 at 4 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 13 1945 to Dec. 26 1945 and that I last saw h. alive on Dec. 26 1945.

Immediate cause of death Monocytoma — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Philip R. Lamdin M.D.
Address Johns Hopkins Hosp. Date Dec 28 45

G35621

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

33a

Registered No. G35621

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1836 E. North Ave.
(c) Hospital or institution:

81

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1812 E. North Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARION DALE BAUER

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: none

4. Sex: Female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: William Bauer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 11.1858

8. AGE: Years 87 | Months 6 | Days 14 | If less than one day ....hr. ....min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name rdward Thomas Elliott
13. Birthplace Ellicott City Md.

MOTHER
14. Maiden Name Mary Ann Cramer
15. Birthplace Ellicott City Md.

16 (a) Informant Mrs. Arthur M. Schmidt
(b) Address 1836 E. North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec.28.1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore Md

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address North Ave. & Broadway

19 DEC 27 1945 (Date received by local registrar) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 25. 1945 at 9.00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 21st. 19 45 to Dec. 25th. 19 45. and that I last saw h or alive on 12/24 19 45.

	Duration
Immediate cause of death: Bronchial Pneumonia	2 days
Due to: LaGrippe	5 days
Due to: ---------	
Other Conditions: Arteriosclerosis	unknown

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. W. Humphrey M. D.
Address 401 E. 25th. St. Date signed 12/26/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

8

X

G356222

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 V

Registered No. G356222

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 113 N. Decker Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 M
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 113 N. Decker Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert Milton Boram (ALBERT MILTON BORAM)

3 (b) If veteran, name war: no

3 (c) Social Security Account No. none

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife Anna Boram

6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) June 24, 1884

8. AGE: Years	Months	Days	If less than one day
61	6	2	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Baltimore Transit Co.

11. Industry or business

FATHER
12. Name Thomas J. Boram
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Mary Welsh
15. Birthplace Conn.

16 (a) Informant Mrs. Anna Boram
(b) Address 113 N. Decker Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-29-45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) (b) Date received by Registrar DEC 27 1945 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-26 1945 at 7:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-1- 1939 to 12-26 1945 and that I last saw h[illegible] alive on 12-26 1945

Immediate cause of death Myocardial degeneration — Duration

Due to Arteriosclerotic heart disease.

Due to Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John J Gould M. D.
Address 147 E. [illegible] Date signed 12-26-45

X

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important. The

035623

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. 035623

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fairmount & N Broadway
(c) Hospital or institution:
Church Home & Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days) 69 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3022 Glenmore Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME XXXXXXXXXXXXXXXXXXXX WILLIAM MEDLEY

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. 212-09-8773

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Mrs Elizabeth Medley
6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) Apr. 16, 1873

8. AGE: Years	Months	Days	If less than one day
72	9	9	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Machinist
11. Industry or business Hammered Piston Ring

FATHER
12. Name Wm B Medley
13. Birthplace Maryland

MOTHER
14. Maiden Name Sarah Jane Hatton
15. Birthplace Maryland

16 (a) Informant Mrs. Elizabeth Medley
(b) Address 3022 GLENMORE AVENUE

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-29-45 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC?
(b) Address NORTH AVE. & BROADWAY

19 DEC 27 1945 (b) Huntington Williams M.D.
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-25 1945 at 5:20 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-20 1945 to 12-25 1945 and that I last saw him alive on 12-25 1945

Immediate cause of death Pulmonary Edema — Duration 5 hrs

Due to Cardiac decompensation — 5 days

Due to Arteriosclerotic Cardiovascular disease

Other Conditions Intestinal obstruction due to Carcinoma-Colon
(Include pregnancy within 3 months of death)

Date of operation 12-24-45

Major findings of operation: Intestinal obstruction, Carcinoma of Sigmoid

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature S. W. Borkovic M. D.
Address Church Home & Hosp Date signed 12-26-45

S.W. Borkovic

VS 180

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

635624

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

16

635624
Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly. The ... number of ... on ... supplies. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1111 N. Kenwood Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMOE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1111N. Kenwood Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DORIS OLIVIA GIBBONS

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.: NONE

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 26, 1898

8. AGE: Years 46 | Months 11 | Days 29 | If less than one day ... hr. ... min.

9. Birthplace CRISFIELD, MARYLAND
(Town, county, and state)

10. Usual Occupation Housekeeper

11. Industry or business

FATHER
12. Name Robert L. Gibbons
13. Birthplace Crisfield, Md.

MOTHER
14. Maiden Name Demmie Blades
15. Birthplace Crisfield, Md.

16 (a) Informant Miss Emily Gibbons
(b) Address 1111 N. Kenwood Avenue

17 (a) Burial (b) Date thereof 12-27-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (a) DEC 27 1945 (b) Hunter for Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 25, 1945 at 1 AM M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 24 1945 to Dec 25 1945, and that I last saw her alive on Dec. 24 1945

	Duration
Immediate cause of death Pulmonary edema	1 day
Due to Acute bronchitis	1 days
Due to	
Other Conditions Spinal TBC	45

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature David Sylvester M.D.
Address 1101 N. Wolfe St. Date signed 12-26-45

106a

Ab - 98033

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

Registered No. G35625

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6hrs.15min.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1339 N. Stockton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Irene Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: C

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Maxwell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4, 1917

8. AGE: Years 28 | Months 5 | Days 19 | If less than one day ..... hr. ..... min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Edward
13. Birthplace Md.

MOTHER
14. Maiden Name Fannie
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals (Rec.
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 12/27/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md. Geo. L. Kelso

18 (a) Funeral director
(b) Address 1303 Pennsylvania Ave

19 (a) DEC 27 1945 (b) Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 23 1945, at 9.05PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-23 1945, to 12-23 1945, and that I last saw h er alive on 12-23 1945.

Immediate cause of death Bronchopneumonia — Duration ?

Due to

Due to

Other Conditions Obesity
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Pneumonia in (bilateral)
of autopsy Cardiac hypertrophy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Margaret Dawson M. D.
Address B.C.H. Date signed 12/26/45

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

107

035626

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 035626

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1408 Presstman St.
(c) Hospital or institution:
16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town, write "Not in Baltimore")
(d) Street No. [redacted] Presstman St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ODAN [redacted] Layton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 2 1912

8. AGE: Years 33 | Months 4 | Days 22 | If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Daniel Layton
13. Birthplace Va.

MOTHER
14. Maiden Name -
15. Birthplace -

16 (a) Informant John Layton
(b) Address 1202 Argyle Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/28/45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Md

18 (a) Funeral director Geo. H. Kelson
(b) Address 1308 Presstman St

19 (a) DEC 27 1945 (Date rec'd by registrar) (b) [illegible] Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 24 1945, at 9:15 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:
IMMEDIATE CAUSE OF DEATH Chronic Myocarditis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury
23. Signature Robert C. Hamilton M.D.
Medical Examiner.
Date signed 12-24-45

G35627

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 B

Registered No. G35627

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5208 Biddison Lane
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 54 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 6
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5208 Biddison Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Augusta Bertha Carter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Fe	Wh	W

6 (b) Name of husband or wife: John Thos. Carter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 26th., 1879

8. AGE: Years	Months	Days	If less than one day
66	8	30 29	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At home

FATHER
12. Name Karl Ziemann
13. Birthplace Germany

MOTHER
14. Maiden Name Wilhelmina Klatt
15. Birthplace Germany

16 (a) Informant Mrs. Clarance Rauber
(b) Address 5208 Biddison Lane

17 (a) Burial (b) Date thereof 12/28/1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Jerusalem Lutheran
Location Baltimore, Maryland

18 (a) Funeral director Lauchheimer Funeral Home
(b) Address 7401 Reisterstown Road

19 (a) DEC 27 1945 (b)
(Date received by Registrar) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 25thv 1945, at 6.30PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 9 1945, to Dec 25 1945, and that I last saw her alive on Dec 25 1945.

Immediate cause of death	Duration
Carcinoma of stomach	1 yr.(?)
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. L. Wilkinson
A. L. Wilkinson, M.D.
Address 5713 Bel Air Rd. Date signed 12/26/45

VS 186

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35628 ✓ G35628

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No.

Note the causes of death clearly and legibly. The correct age is especially important. Physicians: please write the information requested accurately supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1208 W. Lexington
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18"
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1208 W. Lexington St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country ✓

3 (a) FULL NAME Bertha D Gross

3 (b) If veteran, name war,	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	C	Widow

6 (b) Name of husband or wife Richard A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 24 1888

8. AGE: Years	Months	Days	If less than one day
56 57	11 —	— 29	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Lewis L. Thomas
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Smith
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Florence Phillips
(b) Address 1208 W. Lexington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 27 '45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

12-27-1945 Huntington Williams
(Date rec'd by registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/23 1945, at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-2 1945 to 12-23 1945 and that I last saw h[illegible] alive on 12-24 1945

Immediate cause of death Coba Pneumonia 4

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 134 [illegible] Date signed 12-26-45
X

G35629 BALTIMORE CITY HEALTH DEPARTMENT ✓ G35629

CERTIFICATE OF DEATH 83a

Registered No.

Write the causes of death clearly and legibly. Correct age is especially important. Physicians: please write t

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 836 N. Carey St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1b ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 836 N. Carey St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Lucy Hardy
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Joseph
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 18, 1865

8. AGE: Years 80 | Months - | Days 5 | If less than one day hr. min.

9. Birthplace Jefferson County, Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name George Berry
13. Birthplace Jefferson Co. Md.

MOTHER 14. Maiden Name Sophia
15. Birthplace Jefferson Co. Md.

16 (a) Informant Mr. Charles Hardy
(b) Address 128 N. Gilmor St

17 (a) Burial (b) Date thereof Dec. 27 '45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St

19 (a) DEC 27 1945 (b) Thomas J. Williams
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/23/45, at 11 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/20 1945 to 12/23 1945, and that I last saw her alive on 12/23 1945.

Immediate cause of death	Duration
Cerebral apoplexy	
Due to Paralysis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ben Landy M. D.
Address 1/3 Dunn Ave Date signed 12-24-45

VS 150

G35630

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registration No. G35630

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 959 Bennett Place
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 959 Bennett Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Leonard Green.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Color

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6, 1945

8. AGE: Years — | Months 7 | Days 18 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name Leonard Green.
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Bertha Jones.
15. Birthplace Baltimore, Md.

16 (a) Informant Leonard Green.
(b) Address 959 Bennett Place.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 27 '45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) DEC 27 1945 (Date rec'd by registrar) (b) Katie R. Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/24 1945 at 11:4 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/20 1945 to 12/26 1945 and that I last saw him alive on 12/23 1945

Immediate cause of death
Bronchopneumonia
(Bronchitis)
Due to Upper respiratory infection
Due to Flu

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature P. J. Sulsa M. D.
Address 434 E. 33rd St. Date signed 12/27/45

Please write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

VS 150

G35631

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G35631

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important. The ... may be required.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) Not Known

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 147 N. Sexton Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anderson (Nee Ferguson) Mack
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Not Known

8. AGE: Years 56 | Months | Days | If less than one day hr. min.

9. Birthplace Not Known (Town, county, and state)

10. Usual Occupation Not Known

11. Industry or business —

FATHER 12. Name
13. Birthplace Unknown

MOTHER 14. Maiden Name
15. Birthplace Not Known

16 (a) Informant Mrs Gertrude Butler
(b) Address 147 N. Sexton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/28/45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elmer O. Watson
(b) Address 1020 Bradley Ave.

DEC 27 1945 (Date rec'd by registrar) (b) Huntington White Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 23 1945 at 8:15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/17 1945 to 12/23 1945 and that I last saw h[illegible] alive on Dec. 23 1945

Immediate cause of death: Cerebral Hemorrhage — Duration 5 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Sanchez Jr.
Address Mercy Hospital Date signed 12/23/45

H. Sanchez X

VS 150

G35632

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G35632

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: John Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2m
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1304 McElderry St
(If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME Henry Andro

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	M

6 (b) Name of husband or wife Marie Andro
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 17, 1878

8. AGE: Years	Months	Days	If less than one day
67	1	8	hr. min.

9. Birthplace Coperville Valenda, Portugal
(Town, county, and state)

10. Usual Occupation Sailor
11. Industry or business

FATHER
12. Name unknown
13. Birthplace "

MOTHER
14. Maiden Name unknown
15. Birthplace "

16 (a) Informant Marie Andro
(b) Address 1304 McElderry St

17 (a) Burial (b) Date thereof 12/29/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location.....

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brentley ave

19 (a) (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/25 1945, at 5:32 P M

21. I certify that I took charge of the remains described above, held an Inspection Autopsy on the body and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C.V disease

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature C. J. Pulaski M.D.
Medical Examiner.
Date signed 12/26/45

G35633

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G35633 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St. & Rutland Ave.
(c) Hospital or institution:
SINAI HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md. (b) County Anne Arundel
(c) City or town annapolis, md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 47 Randall St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bessie Humphries

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	widow.

6 (b) Name of husband or wife Wm. Humphries
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 21, 1876

8. AGE: Years	Months	Days	If less than one day
69	3	3	hr. min.

9. Birthplace maryland.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name Charles S. Magaha
13. Birthplace Virginia.

MOTHER
14. Maiden Name Kate Hefner.
15. Birthplace maryland.

16 (a) Informant Mrs. C. Humphries.
(b) Address Augusta, Ga.

17 (a) Burial (b) Date thereof Dec 28/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or ~~crematory~~ London Park
Location Frederick Road

18 (a) Funeral director Elmore & Donovan
(b) Address 3615-17 Chestnut Ave.

19 (a) DEC 27 1945 (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 24 1945, at 6.25 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 21 1945, to Dec 24 1945, and that I last saw her alive on Dec 24 1945.

Immediate cause of death	Duration
Arteriosclerotic Heart Disease	
Due to	
Due to	
Other Conditions Diabetes Mellitus	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jeane L. Heuschmann M. D.
Address Sindi Hospital Date signed 12-27-45

93D

G35634 G35634

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

195E Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Penna. (b) County York
(c) City or town Delta
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William C. Williams

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Connie M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1888

8. AGE: Years	Months	Days	If less than one day
57			hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business

FATHER
12. Name Hugh C. Williams
13. Birthplace

MOTHER
14. Maiden Name Cornelia
15. Birthplace

16 (a) Informant William C. Williams, Jr.
(b) Address Delta, Penna.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 31, 1945 (month) (day) (year)
(c) Cemetery or crematory Fatemille
Location Delta, Pa.

18 (a) Funeral director Hubert P. Hankins
(b) Address Delta, Pa.

19 (a) DEC 27 1945 (b)
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 27 1945, at 7:50 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Depressed
Comminuted Fracture of Skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Dec. 26, 1945 Harford Co. M.
(b) Where did injury occur? Caraway, Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Garage While at work? Yes
(d) Means of injury Struck by falling ice

23. Signature Roland Lee Deaton M.D.
Medical Examiner.
Date signed Dec. 27 1945

G35635

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 134a

✓ G35635 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hosp
(d) Length of stay in hospital or inst. (yrs., mos. or days) 2days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 419 N. Washington St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elmira Jester

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: late Ant. Jester

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): April 17 1886

8. AGE: Years	Months	Days	If less than one day
59	8	9	hr. min.

9. Birthplace: Baltimore Md. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business: Home

FATHER
12. Name: Harry Norfolk
13. Birthplace: Md.

MOTHER
14. Maiden Name: Elizabeth Twolley
15. Birthplace: Md.

16 (a) Informant: Walter C. Jester (Son)
(b) Address: 2412 Sisson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 29/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Baltimore
Location Baltimore Md.

18 (a) Funeral director: Frank D. La Mora
(b) Address: 52 N. Morley St.

19 (a) DEC 27 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 26 1945 at 2:15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute pyelonephritis

Due to Nephrolithiasis, bilateral

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed 12-26-45

X

635636

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

635636 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Fourth Balto. Gen. Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1441 Light St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Ann Appy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) ~~Single, married,~~ widowed, or ~~divorced~~ Widowed

6 (b) Name of husband or wife Wm. T. Appy

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug. ?, 1867

8. AGE: Years 78 | Months 4 | Days ? | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation
11. Industry or business At Home

FATHER
12. Name Joseph Carter
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Susanna M. Lightner
15. Birthplace Md.

16 (a) Informant Jesse M. Appy (Son)
(b) Address 2317 E. Jefferson St. (Balto. 5, Md.)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 28, 1945 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Baltimore, Md.

18 (a) Funeral director C. Howard Evans
(b) Address 1400 E. Chas. St. (Balto 2, Md.)

19 (a) DEC 27 1945 (Date rec'd by registrar) Clayton Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 25 1945; at 2:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 22 1945, to Dec 25 1945; and that I last saw him alive on Dec 25 1945.

Immediate cause of death: Cerebral Hemorrhage — Duration 3 days
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury

23. Signature Wm. E. Wheeler, M.D.
Address Fourth Balto. Gen. Date signed D-27-45

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G356637

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G356637 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Beech & 40th Sts.
(c) Hospital or institution: Wyman Park Apts. 13
(d) Length of stay in hospital or inst. (yrs., mos., or days):
(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County:
(c) City or town: Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No.: Beech & 40th Sts.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country:

3 (a) FULL NAME: WILLIAM H. GETTEMULLER

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: 212-10-4494

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Anna W. Gettemuller

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 30, 1879

8. AGE: Years: 66 | Months: 1 | Days: 24 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation: Paint Mfct.

11. Industry or business: Self

FATHER
12. Name: Herman J. Gettemuller
13. Birthplace: Germany

MOTHER
14. Maiden Name: Amelia Merle
15. Birthplace: New York

16 (a) Informant: Mr. Allen Gettemuller
(b) Address: 2002 E. 30th St.

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** 12/27/45 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

DEC 27 1945 (a) (Date received by registrar) (b) Hunting for Williams MD

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 24, 1945, at 10 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 7 1944 to Dec 24 1945 and that I last saw h[illegible] alive on Dec 21 1945

Immediate cause of death: acute Coronary Occlusion — Duration: 1 day

Due to: Arteriosclerotic Heart Disease — Duration: over 1 year

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: George Dennis M. D.

Address 1808 Hanford Date signed 12/27/45

Dr. Sawyer

VS 150

Please write the correct age in especially important. Physicians: please write the causes of death clearly and legibly.

G35638 ✓ G35638

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Eutaw Place
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) 79 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2733 Hugo Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARGARET V. HINTON

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Alfred W. Hinton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 26, 1865

8. AGE: Years	Months	Days	If less than one day
80	1	29	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Julius H. Braum
13. Birthplace Germany

MOTHER
14. Maiden Name Annie -
15. Birthplace Germany

16 (a) Informant Mr. Julius H. Hinton
(b) Address 2733 Hugo Ave.

17 (a) Burial (b) Date thereof 12/28/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER &SONS
(b) Address Balto., Md.

19 (a) DEC 27 1945 (b) Hennington Williams, M.D.
(Date rec'd by Local Registrar) Registrar

MEDICAL CERTIFICATION A.

20. DATE OF DEATH Dec. 25, 1945, at 11:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1945 to Dec 25 1945. and that I last saw her alive on Dec 25 1945.

Immediate cause of death	Duration
Acute cardiac Dysphagia	5 days
Pulmonary Edema	
Due to Arterio Sclerosis	10 yrs.
Right Cloth Fracture	
Due to Cerebral Sclerosis	5 yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Fred Zimmerman M. D.
Address 9858 Halford Date signed 12/26/45

VS 150

G35639

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

G35639 Registered No.

Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1149 Scott St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1149 Scott St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FREDERICK J. ENGELHAUPT

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
none	none	Male	White	Married

6 (b) Name of husband or wife Pauline Engelhaupt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 28, 1868

8. AGE: Years	Months	Days	If less than one day
77	1	27	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Regina Foster
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Pauline Engelhaupt
(b) Address 1149 Scott St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/28/45 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) DEC 27 1945 (b) Huntington Williamsport, Md.

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH Dec. 25, 1945, at 10:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 18 1945 to Dec. 25 1945. and that I last saw h alive on Dec 25 1945

Immediate cause of death	Duration
Broncho - Pneumonia	1 week
Due to Myocarditis	2 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. F. Kates M. D.
Address 517 Aceb St Date signed 12/26/45

H. F. Kates X

G35640

BALTIMORE CITY HEALTH DEPARTMENT

TH. 86102

CERTIFICATE OF DEATH 13B

Registered No. G35640

Type or use ink. Entries must be complete and correct. Causes of death must be clearly and legibly stated. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1- 11-5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 21 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1617 W. Lafayette ~~St~~ Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME PARTEE Ethel Stepney

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 24th 1923

8. AGE: Years	Months	Days	If less than one day
22	11	0	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Levi Partee
13. Birthplace N. C

MOTHER
14. Maiden Name Hallie Johnson
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (b) Date thereof 12/28/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location

18 (a) Funeral director Joseph D. Lockard, Son & Co.
(b) Address

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

DEC 27 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 24th. 1945 at 10.45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 21st 1945, to 1945, and that I last saw h~~er~~ alive on Dec. 24 1945

Immediate cause of death: Malnutrition & Cachexia — Duration 2

Due to Jejuno-cutaneous fistula

Due to Tuberculous Enteritis and Tuberculosis of Pelvic Organs

Other Conditions Pulmonary Tuberculosis, Reinfiltrative

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert H. Copeland Jr. M. D.
Address Balto. City Hosp Date signed 12/26/45

G35641 — BALTIMORE CITY HEALTH DEPARTMENT — G35641 Registered No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Ave
(c) Hospital or institution: St Agnes Hospital of
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Xdcd

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2713 E. Biddle St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph A. Kraft.

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Elsie M. Kraft

6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Mar 21 1873

8. AGE: Years 72 | Months 9 | Days 56 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Retired Store Keeper

11. Industry or business

FATHER
12. Name Henry Kraft.
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Mary Eiling
15. Birthplace Baltimore Md

16 (a) Informant Elsie M. Kraft
(b) Address 2713 E Biddle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 31-1945 (month) (day) (year)
(c) Cemetery or crematory Baltimore City
Location

18 (a) Funeral director Mrs. John W. Teufel-Son
(b) Address 801 W. Fayette St

19 12 29 1945 (Date rec'd by registrar) (b) Lentington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-27 1945 at 4:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-20 1945 to 12-27 1945 and that I last saw him alive on 12-27 1945.

Immediate cause of death Cerebr Cardio-Respiratory Failure — Duration

Due to Cerebro-scler. Cardio-Vascular disease with

Due to Congestion and Complete left hemiplegia.

Other Conditions

Operation (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Custum T. Hall Jr. M.D.
Address St. Agnes Hosp Date signed 12/29/45

VS 180

X

Suggest age is especially important. Physicians: please write the causes of death clearly and legibly.

G35642 BALTIMORE CITY HEALTH DEPARTMENT ✓ G35642
CERTIFICATE OF DEATH 131a Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3520 Helton Road
(c) Hospital or institution: Mrs. Shriners Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 da
(e) Length of stay in Baltimore (yrs., mos., or days) 43 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2500 James Pl. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Roza Struska

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W.	Widow

6 (b) Name of husband or wife Louis Struska
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Jan 30. 1871

8. AGE: Years	Months	Days	If less than one day
74	10	24	hr. min.

9. Birthplace Austria Hungary (Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER 12. Name Meyer
13. Birthplace Austria Hungary

MOTHER 14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant Joseph N. Struska
(b) Address 2307 Eastern Heights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 28 1945 (month) (day) (year)
(c) Cemetery or crematory Western
Location City

18 (a) Funeral director Mrs. Mrs. John W. Teufel Son
(b) Address 801 W. Fayette St
(c) Huntington Williams

DEC 27 1945 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 25 1945, at 4.9 M
21. I certify that death occurred on the date above stated; that I attended deceased from Dec 11 1945 to Dec 25 45, and that I last saw h alive on 19

Immediate cause of death Bronchopneumonia — Duration 3 d
Due to Cardiac Decompensation — 7 Days
Due to Chronic Arteriosclerosis Nephritis — 7 Days
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Geo A Stevens M. D.
Address 2878 Harford Ave Date signed

VS 150

X

G35643 — Warden — G35643

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1336

Registered No.

Please write the cause of death clearly and legibly. Physicians: please write the age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun
(c) Hospital or institution: Franklin Square Hospital 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 329 N Carrollton Ave
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Warden, Howard

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	N	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 10-1886

8. AGE: Years	Months	Days	If less than one day
59 ✓	9	16	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name ? Warden
13. Birthplace Md.

MOTHER — 14. Maiden Name Mary ?
15. Birthplace W. Va.

16 (a) Informant William Warden
(b) Address 902 - Edmonson Ave. - Catonsville

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-29-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cemetery
Location Md.

18 (a) Funeral director Nicholas Halstead
(b) Address 918 Druid Hill Ave.

19 (a) 12-27 1945 (Date received by registrar) (b) Huntington Williams M.D. (Registrar)

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-26-1945, at 1 15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-24-1945 to 12-26-1945 and that I last saw him alive on 12-26-1945

Immediate cause of death	Duration
Pneumonia	
Due to Bilateral hydronephrosis	
Due to	
Other Conditions Carcinoma	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: Bilat Hydronephrosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work? —
(e) Means of injury —

23. Signature N K Kerrigan M. D.
Address Franklin Square Hosp. Date signed 12-27-45

Balto Co

G35644

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G35644

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Died
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4833 Belair Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carroll Kirkwood

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 18th 1882

8. AGE: Years 63 64 | Months 1 7 | Days 6 | If less than one day hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation Night Watchman
11. Industry or business Lakewood Laundry

FATHER
12. Name Jacob F. Kirkwood
13. Birthplace Md

MOTHER
14. Maiden Name —
15. Birthplace Md

16 (a) Informant Mrs. Charles Miller
(b) Address 4833 Belair Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 28th 1945 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Road

18 (a) Funeral director Leo G. Leach
(b) Address 1701-03 N. Patterson Park Ave

19 DEC 27 1945 (Date rec'd by registrar) (b) Huntington Pharmacy Md

VS-151

MEDICAL CERTIFICATION

20. DATE OF DEATH 24 Dec 1945, at 7.45 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William G. Hedges M.D.
Medical Examiner.
Date signed 25 Dec 45

G35645

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 B

G35645 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greenspring Ave.
(c) Hospital or institution: Childrens Hospital School
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 1/2 mos (+19 days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 238 S. Washington St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Bernard Wasowicz

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	child

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-6-42

8. AGE: Years	Months	Days	If less than one day
3	-3	-20	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation child
11. Industry or business —

FATHER
12. Name Walter Victor Wasowicz
13. Birthplace Baltimore Maryland

MOTHER
14. Maiden Name Clara Krpinski
15. Birthplace Laurel Maryland -

16 (a) Informant Walter Victor Wasowicz
(b) Address 238 S. Washington St. Balto 5 md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/29/45 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Mt. Carmel Road

18 (a) Funeral director M. J. Sadowski & Son
(b) Address 1808 Eastern Avenue

19 (a) DEC 27 1945 (Local Registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 26th 1945 at 7 54 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 11 1945 to Dec. 26 1945, and that I last saw him alive on Dec. 26 1945.

Immediate cause of death Tuberculous meningitis — Duration
Due to Tuberculosis of left hip
Due to
Other Conditions Pulmonary tuberculosis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Raymond E. Lombard
Address Children's Hospital School Date signed 12-26-45 (M. D.)

VS 2

G35646

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 43D

Registered No. G35646

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2621 Boone St.
(c) Hospital or institution Johns Hopkins Hospital DOA
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto — (If outside city or town limits, write RURAL and give town)
(d) Street No. 2621 Boone St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anthony Watties

3 (b) If veteran, name war

3 (c) Social Security account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1893

8. AGE: Years	Months	Days	If less than one day
52			hr. min.

9. Birthplace Virginia (town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Anthony Watties
13. Birthplace Va

MOTHER
14. Maiden Name Margaret P.
15. Birthplace Va

16 (a) Informant Louise Watties
(b) Address 2621 Boone St

17 (a) Burial (b) Date thereof 12-27-45 (month) (day) (year)
(burial, cremation, or removal)
(c) Cemetery or crematory Mt Calvary
Location A. G. Co

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St

19 DEC 27 1945 (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 23 Dec 1945, at 5:40 A M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Arteriosclerotic Cardio-
Vascular disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J Helfrich M.D.
Medical Examiner.
Date signed 23 Dec 45

VS 151

G35647

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G35647

Local No. 131a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 324 E. 20½ St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 M
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 324 E. 20½ St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizbeth Cooper

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Col	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1893

8. AGE: Years	Months	Days	If less than one day
52			hr. min.

9. Birthplace Virginia (Town, county and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER 12. Name James Fowlkes

13. Birthplace Va

MOTHER 14. Maiden Name Susie Morton

15. Birthplace Va

16 (a) Informant James H. Profit

(b) Address 1717 Maryland ave

17 (a) Burial (b) Date thereof 12-28-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location B. G. Co

18 (a) Funeral director Haynes Sanders

(b) Address 1412 E. Preston St

DEC 27 1945 (b)
(Date rec'd by Registrar)

Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 24 1945 at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1945 to Dec 24 1945 and that I last saw h alive on Dec. 24 1945

Immediate cause of death

Uremia Interstitial Nephritis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

Duration
1 mo

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis A. Feldman M. D.

Address 2829 Guilford Ave Date signed Dec 27 1945

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Form—J-M-21—M&T—1000 Blks.

G35648 Fiege G35648

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 94a

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1801 N. Wolfe ST. WARD)

2-FULL NAME John C. Fiege q15

(a) RESIDENCE NO. 1801 N. Wolfe ST., WARD S-3-214-03-2676

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Helen Faul

6 DATE OF BIRTH (month, day, and year) 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) J. F. Filbert

(c) Name of employer Filbert

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Henry P. Fiege

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Ruth Kuman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mrs Helen Fiege

(Address) 1801 N. Wolfe St

15 Filed DEC 27 1945, 19 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 26 1945

17 I HEREBY CERTIFY, That I attended deceased from Dec 26, 1945, to Dec 26, 1945, that I last saw h alive on Dec 26, 1945, and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Coronary Occlusion

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Hypertension, arterio sclerosis (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Janet Fraher, M. D.

12/29, 1945 (Address) 1823 N. Wolfe St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pikesville Cemetery — DATE OF BURIAL Dec. 28 1945

20 UNDERTAKER Rita Wiedefeld X — ADDRESS 917 Druid Park Dr

Howard J. Mathias, M.D.

G35649

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

G35649 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 132 W. Randall St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 23
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 132 W. Randall St (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Reuben D. Smith

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Louise Smith
6 (c) If alive, give age: 72 years
7. Birth date of deceased (mo., day, yr.): June 15, 1875
8. AGE: Years: 70 Months: 6 Days: 12 If less than one day ... hr. ... min.
9. Birthplace: Balto. Md (Town, county, and state)
10. Usual Occupation: Pleasure (Gov't Electric)
11. Industry or business: Hand 60.

FATHER
12. Name: Reuben Smith
13. Birthplace: Md

MOTHER
14. Maiden Name: Ruth ?
15. Birthplace: Md

16 (a) Informant: Louise Smith
(b) Address: 132 W. Randall St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Dec. 31, 1945 (month) (day) (year)
(c) Cemetery or crematory: Western Cem
Location: Balto Md

18 (a) Funeral director: P. C. Howard Evans
(b) Address: 1005 Charles St. Balto 30

19 (a) ... (Date rec'd by registrar) (b) ... (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 27, 1945, at 2 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/21 1945 to 12/27 1945, and that I last saw him alive on 12/26 1945.

Immediate cause of death: Coronary thrombosis — Duration: 5 days
Due to: —
Due to: —
Other Conditions: Hypertension and cardiovascular disease — 2
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:
23. Signature: Harry Deitel
Address: 126 Fondue St Date signed: 12/27/45

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G35650

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G35650

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1816 Clifton Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 yrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1816 Clifton Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John B. Ward

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Widower

6 (b) Name of husband or wife Mary E. Ward, Dec'd
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 24-1866.

8. AGE: Years	Months	Days	If less than one day
79	6	28	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Telegrapher-Operator
11. Industry or business

FATHER
12. Name Barney Ward.
13. Birthplace County Cork. Ireland.

MOTHER
14. Maiden Name Mary Delaney
15. Birthplace Galway Ireland.

16 (a) Informant Mr. Martin J. Ward
(b) Address 3021 Garrison Blvd.

17 (a) Burial (b) Date thereof Dec. 29-1945
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Baltimore Md.

18 (a) Funeral director Maurice Cook Dyer
(b) Address 1600 W. North Ave.

19 DEC 27 1945 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/27/45 19..., at 6:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH (a) Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John Adams, M.D.
Medical Examiner.
Date signed

VS 151

635651

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 12B

Registered No. 635651

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1703 Bolton St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1703 Bolton St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Merritt William Bowers

3 (b) If veteran, name war

3 (c) Social Security Account No. 196-09-1997

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Margaret

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1901

8. AGE: Years 44 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace Mitchellville Pa (Town, county, and state)

10. Usual Occupation Electrician

11. Industry or business

FATHER 12. Name William G Bowers

13. Birthplace Indiana

MOTHER 14. Maiden Name Charlotte

15. Birthplace Indiana

16 (a) Informant Margaret Bowers

(b) Address 1703 Bolton St

17 (a) removal (Burial, cremation, or removal) (b) Date thereof 12-27-45 (month) (day) (year)

(c) Cemetery or crematory

Location Johnstown Pa

18 (a) Funeral director Jack Lewis Inc

(b) Address 2120 Eutaw Place

DEC 27 1945 (Date rec'd by registrar) (b) Huntingtown Hill Baptist

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-26- 1945 at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-1- 1945 to 12-26-1945 and that I last saw h[im] alive on 12-26-1945

Immediate cause of death Pulmonary Tuberculosis — Duration Fifteen or more years

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Wm Greenfield M. D.

Address 1821 Eutaw Pl. Date signed 12/27/45

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35652 BALTIMORE CITY HEALTH DEPARTMENT G35652

CERTIFICATE OF DEATH 556

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Belvedere & Greenspring
(c) Hospital or institution: Lewindale
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 wks
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. Belvedere & Greenspring
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Brotman

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Benjamin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years: 63 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Hosp Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-27-45 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Belair Rd & Hamilton Ave

18 (a) Funeral director Jos C Levin Sons
(b) Address 1439 E. Baltimore St

19 (a) DEC 27 1945 (b)
(Date rec'd by registrar) Huntington Wollenweber, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 26 1945, at 10.15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-6 1945 to 12-26 1945, and that I last saw h[illegible] alive on 12-26 1945

Immediate cause of death: Malignant Lymphadenoma of neck — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H Edmund Levin
Address Lewindale Date signed 12/26/45 D.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

260798

G35653

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G35653

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 1/4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1803 Lamby Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Billings

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-13-3740

4. Sex Male | 5. Color or race Black | 6 (a) Single, married, widowed or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 29, 95

8. AGE: Years 50 | Months 1 | Days 17 | If less than one day hr. min.

9. Birthplace S. Carolina (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Inge Billings
13. Birthplace S. Carolina

MOTHER
14. Maiden Name Adda Bettica
15. Birthplace S. Carolina

16 (a) Informant Friends
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 27-1945 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location Balto. Co. Md.

18 (a) Funeral director Robert E. Wilkinson
(b) Address 1515 McElderry St

19 (a) 12-27 1945 (Date rec'd by registrar) (b) Huntington for Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 13, 1945, at 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 24 1945, to Dec. 13 1945 and that I last saw h[illegible] alive on Dec. 13 1945

Immediate cause of death: Cerebral Hemmhage — Duration 1 Day

Due to: Arterial Hypertension — 2

Due to: Chronic Glomerulo-Nephritis — ?

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Freeman J. Stephens
Address Johns Hopkins Hosp. Date signed 12/13/45 D.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G35654 G35654

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V13B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address St. Joseph's Hosp.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2625 Maura St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary V. Gordon
3 (b) If veteran, name war
3 (c) Social Security Account No. 217-07-6797

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct-20-1922

8. AGE: Years	Months	Days	If less than one day
23	2	6	hr. min.

9. Birthplace Balto Md. (Town, county, and state)
10. Usual Occupation Secretary
11. Industry or business Dentist

FATHER
12. Name Charles E. Gordon
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Catherine A Mayers
15. Birthplace Balto. Md.

16 (a) Informant Catherine A Mayers
(b) Address 2625 Maura St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-29-45 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North Ave.

18 (a) Funeral director John C Melly Jr
(b) Address 2413 Huntingdon Ave

19 (a) DEC 27 1945 (Date rec'd by registrar) (b)

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-26- 1945, at 4:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-12 1945 to 12-26 1945 and that I last saw her alive on 12-25 1945

Immediate cause of death	Duration
Respiratory failure	
Due to acute pneumonia	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm H. Frank
Address c/o H. Jos. Hosp. Date signed 12-26-45

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

VS 150

G35655

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G35655 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Providence Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1124 N. Stricker St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Willie Meekins

3 (b) If veteran, name war: World War #2
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 25, 1905

8. AGE: Years 40 | Months 1 | Days - | If less than one day hr. min.

Birthplace Hamlet N. C. (Town, county, and state)

10. Usual Occupation Porter
11. Industry or business

FATHER
12. Name Phil Meekins
13. Birthplace N. C.

MOTHER
14. Maiden Name Josephine
15. Birthplace N. C.

16 (a) Informant Annie Meekins
(b) Address 1124 N. Stricker St.

17 (a) Burial & Removal (Burial, cremation, or removal) (b) Date thereof 12-28-45 (month) (day) (year)
(c) Cemetery or crematory Hamlet, N. C.
Location Hamlet, N. C.

18 (a) Funeral director William A. Jackson
(b) Address 916 Pennsylvania Ave.

19 (a) (Date rec'd by registrar) DEC 27 1945 (b) Registrar for William Buck, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/25 1945, at 5:20 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. L. Lubinski M.D. Medical Examiner.
Date signed 12/26/45

635656 4844071

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V469

635656 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: ~~JOHNS HOPKINS HOSPITAL~~ JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Harford
(c) City or town Belair
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert. Everett.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male.

5. Color or race: White

6 (a) Single, married, widowed, or divorced: divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-20-00

8. AGE: Years 45 | Months 11 | Days 7 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Mechanic

11. Industry or business

FATHER 12. Name Waeton Everett

13. Birthplace Md

MOTHER 14. Maiden Name Rusella Mason

15. Birthplace Md

16 (a) Informant ~~JOHNS HOPKINS HOSPITAL~~ Records

(b) Address

17 (a) Burial (b) Date thereof Dec 29 1945
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Carmel
Location Emmorton, Harford Co.

18 (a) Funeral director W. H. McComas & Son

(b) Address Abingdon, Md.

27 1945
(Date rec'd by registrar)

Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

A

20. DATE OF DEATH Dec. 27 1945 at 2.11 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 21 1945 to Dec. 27 1945, and that I last saw h.~~e~~r alive on Dec. 27 1945

Immediate cause of death	Duration
Bronchopneumonia - Right	
Due to Spontaneous Pneumothorax from Asthma and emphysema	
Due to	
Other conditions Adenocarcinoma of Pancreas with regional metastases	

(Include pregnancy within 3 months of death)

Date of operation December 1945

Major findings of operation Adenocarcinoma of pancreas, Biliary obstruction

Autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Esther Williams Kellmann M.D.

Address Johns Hopkins Hospital Date signed Dec 29 1945

X

635657

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

635657 Registered No.

Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important. Penalty for refusing to supply information or for supplying false information is a fine of not more than $100.00 or imprisonment for not more than 60 days, or both (Sec. 251, Art. 27, Code of Public Local Laws of Baltimore City).

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1820 N.MOTNFORD AVE.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1820 N.MONTFORD AVE.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN C.HOCHREIN

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of husband or wife FANNIE C.HOCHREIN
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAR.4 1899

8. AGE: Years	Months	Days	If less than one day
46	9	21	hr. min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)
10. Usual Occupation POLICE OFFICER TRAFFIC
11. Industry or business B.P.D.

FATHER
12. Name JOSEPH HOCHREIN
13. Birthplace GERMANY

MOTHER
14. Maiden Name ELIZABETH HUEBSCHMAN
15. Birthplace GERMANY

16 (a) Informant FANNIE C.HOCHREIN(WIFE)
(b) Address 1820 N.MONTFORD AVE.

17 (a) BURIAL (b) Date thereof DEC.28/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory BALTIMORE
Location END OF EAST NORTH AVE.

18 (a) Funeral director Lilly & Zeiler inc.
(b) Address 403 S.WOLFE ST.

19 (a) (b)
(Date rec'd by registrar) Huntington Williams M.D.
12 1945
VS 150

MEDICAL CERTIFICATION AM.

20. DATE OF DEATH DEC.25 1945 at 9/30M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/25 1945 to 12/29 1945 and that I last saw h[illegible] alive on 12/29 1945.

Immediate cause of death exhaustion

	Duration
Due to carcinoma of stomach	
Due to	
Other Conditions 8/10/45	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: Extensive carcinoma stomach
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature S.Edmund M. D.
Address medical Tolls Bldg Date signed

X

G35658

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G35658 Registered No. 4873

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 115 W Culey
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 115 N Culey
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hilda Chesser

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	widowed

6 (b) Name of husband or wife John J Chesser

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 12 1899

8. AGE: Years	Months	Days	If less than one day
46	9	13	hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER
12. Name Martin Lyell
13. Birthplace Va

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Mrs Doug Washkevich
(b) Address 115 N Culey St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) Dec (day) 29 (year)
(c) Cemetery or crematory Mt Olive
Location Randallstown Md

18 (a) Funeral director Ulman Funeral Home
(b) Address 2008 Orleans St

19 (a) (Date rec'd by registrar) (Signature of registrar)

DEC 27 1945
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 25 1945, at 8 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1944 to Dec 25 1945 and that I last saw h[er] alive on Dec 25 1945

Immediate cause of death Carcinomatosis
Primary in uterus

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jack J Singer M.D.
Address 508 E Monument Date signed 12-27-45 M. D.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

X

635659

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1940

635659 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Northwood Shopping Center
(c) Hospital or institution: Loch Raven Boulevard
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 y
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1822 Northgate
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Levin Phillips

3 (b) If veteran, name war —

3 (c) Social Security Account No. 220-03-9030

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Crystal P Phillips

6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) Mar 8 1901

8. AGE: Years 47 | Months 9 | Days 17 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation President Phillips

11. Industry or business Corporation

FATHER 12. Name Howard L Phillips

13. Birthplace Md

MOTHER 14. Maiden Name Jennie L Goff

15. Birthplace Baltimore

16 (a) Informant Harry R Phillips

(b) Address 3904 Canterbury Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12 Dec 1945 (month) (day) (year)

(c) Cemetery or crematory Woodlawn Cem

Location Rural

18 (a) Funeral director Fellrich Funeral Home

(b) Address 2008 Orleans St

19 (a) Filed DEC 13 1945 (b) Huntington Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/26/45 19 ____, at 9:15 P.M.

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury ____ at ____ M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature John R Davis M.D.
Medical Examiner.

Date signed 12/27/45

635660

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

635660 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green
(c) Hospital or institution:
University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Westminister
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jeanette Bollinger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband Edward

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 12, 1896

8. AGE: Years 49 | Months 9 | Days 15 | If less than one day ... hr. ... min.

9. Birthplace (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name George Owens
13. Birthplace Md.

MOTHER
14. Maiden Name Martha Caples
15. Birthplace Md.

16 (a) Informant Edward Bollinger
(b) Address Westminster Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-30-45 (month) (day) (year)
(c) Cemetery or crematory Deer Park.
Location Snallmount, Carroll Co. Md.

18 (a) Funeral director C. M. Wall
(b) Address Westfield Md

19 (a) DEC 28 1945 Huntington Williams, M.D. (Date rec'd by registrar) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 27 1945, at 12:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/27 1945, to 12/27 19..., and that I last saw h.s. alive on 12/27 19 61.

Immediate cause of death Resp failure — Duration

Due to Diabetes acidosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Richard O. Hann M.D.
Address Univ. Hosp. Date signed 12/28.

G35661 BALTIMORE CITY HEALTH DEPARTMENT G35661

CERTIFICATE OF DEATH

Registered No. 1634

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 638 W. Lombard St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Herbert Hardesty

3 (b) If veteran, name war: W. W. #2
3 (c) Social Security Account No.:

4. Sex: Male | 5. Color or race: White | 6 (a) Single, ~~married, widowed,~~ or divorced: Single

6 (b) Name of husband or wife:
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Sept 25 1904

8. AGE: Years: 41 | Months: 3 2 | Days: 0 29 | If less than one day: hr. min.

9. Birthplace: Calvert Co. Md.
(Town, county, and state)

10. Usual Occupation: 2
11. Industry or business: 2

FATHER
12. Name: John W. Hardesty
13. Birthplace: Md.

MOTHER
14. Maiden Name: Annie E. Addison
15. Birthplace: Md.

16 (a) Informant: Gertrude Wood
(b) Address: Ridge Rd. - Woodlawn Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/29/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Mt. Olivet
Location: Balto. Md.

18 (a) Funeral director: William Cook Inc
(b) Address: 1207 St. Paul St.

19 (a) (Date rec'd by registrar) Harrington for Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 24 1945, at 11:30 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation
due to carbon monoxide

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Dec. 24 1945 10 P M.
(b) Where did injury occur? 638 W. Lombard St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Inhaled gas from stove

23. Signature Robert L. Graham M.D.
Medical Examiner.
Date signed 12-26-45

CC VS FS 1945

G35662

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G35662 Registered No. 1122 B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden & Madison Ave
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1567 Caswell St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Evelyn Haynes

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: Fe
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife:
6 (c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.) August 31 1873
8. AGE: Years 72 | Months 3 | Days 26 | If less than one day hr. min.
9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Charles F. Haynes
13. Birthplace Md

MOTHER
14. Maiden Name Lita Unknown
15. Birthplace England

16 (a) Informant Austin G. Haynes
(b) Address Silver Spring Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/29/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Western
Location Balto. Md.
18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul st.

DEC 29 1945 (Date rec'd by registrar) (b) Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 26th 1945, at 4 50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 24 1945, to Dec 26 1945, and that I last saw her alive on Dec 26 1945.

Immediate cause of death	Duration
Circulatory collapse	
Due to Intestinal obstruction	
Due to Perforated Ca of bowel	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature C. E. Gonzalez M. D.
Address Maryland G. Hospital Date signed 12/27/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35663

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1108

Registered No. G35663

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 734 W. Franklin St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 734 W. Franklin St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY SPRIGGS ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 28, 1888

8. AGE: Years	Months	Days	If less than one day
57	4	27	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Jesse Spriggs
13. Birthplace Md.

MOTHER
14. Maiden Name Rebecca Grass
15. Birthplace Md

16 (a) Informant Mrs Rebecca Grass
(b) Address 734 W. Franklin St.

17 (a) Burial (b) Date thereof 12-28-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory John Wesly Cem
Location Brook's Chapel, Calvert Co. Md.
18 (a) Funeral dir. Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

DEC 28 1945 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION P

20. DATE OF DEATH Dec. 24, 1945, at 3:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/1 1945 to 12/24 1945 and that I last saw h[illegible] alive on Dec. 24 1945

Immediate cause of death John C Williams — Duration 4 hrs.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address [illegible] Date signed 12/27/45

X

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35664

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G35664 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1427 Mc Henry St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1427 Mc Henry St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary L. F. Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Late Ferdinand P.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mch. 5, 1860

8. AGE: Years 85 | Months 9 | Days 19 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name —
13. Birthplace Germany

MOTHER 14. Maiden Name —
15. Birthplace Germany

16 (a) Informant Mrs. Earl Pennington
(b) Address 1427 Mc Henry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/28/45 (month) (day) (year)
(c) Cemetery or crematory Bapt. National
Location 3445 Frederick Rd.

18 (a) Funeral director Henry H. Whitacre
(b) Address 1010 E. Monument St.

12 28 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/24/45, 19..., at ... M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-24 1945 to 12-24 1945, and that I last saw her alive on 12-24 1945

Immediate cause of death: Broncho pneumonia — Duration unknown

Due to:

Due to:

Other Conditions: generalized arterio-sclerosis

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Nathan Rosen M. D.
Address 206 S. Gilmor St. Date signed 12-27-45

VS 150

G35665

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G35665 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 22 S. Athal Ave
(c) Hospital or institution: General German Aged People's Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 Yrs
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 22 S. Athal Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Schwedner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 16, 1860

8. AGE: Years 85 | Months 6 | Days 10 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Adam Schwedner
13. Birthplace Germany

MOTHER
14. Maiden Name Lottie Denhardt
15. Birthplace Germany

16 (a) Informant Mr. J. Geo. Walz
(b) Address 22 S. Athal Ave.

17 (a) Burial (b) Date thereof 12/28/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Baltimore
Location North Ave. & Loudon Pk.

18 (a) Funeral director Harry H. Kirby
(b) Address 401 E. Monument Ave.

DEC 28 1945
(a) (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION 1/15

20. DATE OF DEATH 12/26/45. 19 at P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 8/45 Dec. 26/45 19
and that I last saw her alive on Dec. 24/45

Immediate cause of death	Duration
Arterio-Sclerosis	Unknown.
Due to	
Due to	3 days.
Other Conditions Broncho-Pneumonia	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry Hurd Church M. D.
Address 903 Hamilton Date signed Dec 27/45

VS 150

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

535666

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. 535666

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 515 Millington Lane
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 - 5
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 515 Millington Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles H. Hoffman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. widowed

6 (b) Name of husband or wife Florence A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 1879

8. AGE: Years Abt-66 | Months | Days | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Westinghouse Elec. Co

FATHER
12. Name Chas. H. Hoffman
13. Birthplace Va.

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Carlon C. Hoffman
(b) Address 1204 Leeds Bergen

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/28/45. (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location 2930 Frederick Rd.

18 (a) Funeral director Harry H. Nitzke
(b) Address 4101 Edmondson Ave

DEC 28 1945
(Date rec'd by registrar)

19 (a) (b) Huntington Wilkinson, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 25, 1945 at 2:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 24 1945 to Dec. 25 1945 and that I last saw h[illegible] alive on Dec. 24, 1945

Immediate cause of death	Duration
Coronic Failure	5 wks.
Due to Coronary Occlusion	10 days.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ted Ellison M. D.
Address 1649 R 4 X Tom Ave - Date signed 12/27/45

VS 150

G35667 SARA Botts G35667

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto General 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dot
(e) Length of stay in Baltimore (yrs., mos., or days) 4

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 132 W. Hamburg St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sara Botts

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: W

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years: 60 | Months | Days | If less than one day: hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Rudolph Patterson
(b) Address 138 W Hamburg St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/29/45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balto City

18 (a) Funeral director Daniel L Brown Sr
(b) Address 108 W Montgomery St

19 DEC 28 1945 (Do not write or sign) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/22 1945 3:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Hypocardiac Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature P. J. Spadinska M.D.
Medical Examiner.
Date signed 12/23/45

VS 151

G35668

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. G35668

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 116 N. Eden St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1900

8. AGE: Years 45 | Months | Days | If less than one day hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant Thelma Brown

(b) Address 124 W West St

17 (a) Burial (b) Date thereof 12/29/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Woodlawn

Location A. A. Co. Md

18 (a) Funeral director Isaiah L Brownston

(b) Address 08 W Montgomery St

19 (a) DEC 28 1945 (b) Huntington Williams Registrar
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 24 1945, at 8:05 P.M.

21. I certify that I took charge of the remains described above, held an ____ thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Chronic Myocardial degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury ____ t ____ M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Robert L. Fretterd M.D.
Medical Examiner.

Date signed 12-24

635669

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 192a

Registered No. 635669

Please write the causes of death clearly and legibly. Physicians: please correct age is especially important. Information should be carefully supplied. Use

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution: East Monument St
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 22 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 316 Parkave (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country China

3 (a) FULL NAME Lieu Yee

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: Yellow
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Mrs Yee
6 (c) If alive, give age 49 years (Abroad)
7. Birth date of deceased (mo., day, yr.) Abt-1896
8. AGE: Years 49 | Months — | Days — | If less than one day ____ hr. ____ min.
9. Birthplace China (Town, county, and state)
10. Usual Occupation none
11. Industry or business —

FATHER
12. Name Not known
13. Birthplace China.

MOTHER
14. Maiden Name Not known
15. Birthplace China.

16 (a) Informant Lieu Song - (Brother)
(b) Address 121 Monument E

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-29-45 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Woodlawn

18 (a) Funeral director Stewart Mortuary Co.
(b) Address 108 W North Ave.

19 (Date rec'd by Registrar) DEC 28 1945 Huntingtown Williams, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/26 1945, at 9:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/19 1945 to 12/26 1945, and that I last saw h[illegible] alive on 12/26 1945.

Immediate cause of death Heart failure — Duration

Due to Aortic insufficiency — Subacute bacterial endocarditis (?)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benson Ruth M. D.
Address Sinai Hosp Date signed 12/27/45

VS 150

G35670

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √94a

Registered No. G35670

Please write the causes of death clearly and legibly. The correct age is especially important. Physicians: please write legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6420 Reisterstown
(c) Hospital or institution: Mount Hope Retreat
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 mos 10 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 7 mos. 10 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore, Md. 21
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6420 Reisterstown Rd.
(If rural give location)
(e) Citizen of foreign country? — No — (Yes or No)
If yes, name country —

3 (a) FULL NAME Sister Veronica McHale

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race white | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) January 15, 1856

8. AGE: Years	Months	Days	If less than one day
89	11	12	hr. min.

9. Birthplace West Virginia (Town, county, and state)
10. Usual Occupation Religious
11. Industry or business

FATHER 12. Name Patrick McHale
13. Birthplace Ireland
MOTHER 14. Maiden Name Mary Fahey
15. Birthplace Ireland

16 (a) Informant Mount Hope Retreat
(b) Address 6420 Reisterstown Rd. Balto 15, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-29-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Hope
Location Baltimore

18 (a) Funeral director Sherwood Mcgrath Co.
(b) Address 1018 North Ave.

19 (a) DEC 28 1945 (Date rec'd by registrar) (b) Hunting Tower Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 27 1945, at 4:13 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 17 1945 to Dec. 27 1945, and that I last saw h[illegible] alive on Dec. 26 1945.

Immediate cause of death Myocardial Infarcts — Duration 1 mo.
Due to Arteriosclerosis — Duration ?
Due to —
Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury —

23. Signature H. S. Alazia M. D.
Address 33 W. Lafayette Ave. Date signed —

X

635571 Dr. Cooper 2201 North Ave. & Eutaw Place

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

635671 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3019 Ailsa Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-B
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3019 Ailsa Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Doris Louise Muhlenfeld

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife ---------
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 28, 1919

8. AGE: Years	Months	Days	If less than one day
25	11	30 2/9	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

MOTHER / FATHER
12. Name George W. Muhlenfeld
13. Birthplace Maryland

MOTHER
14. Maiden Name Hannah Schlutter
15. Birthplace Maryland

16 (a) Informant Mrs. Louise Tatem
(b) Address 3019 Ailsa Avenue-14-

17 (a) Burial- (Burial, cremation, or removal) (b) Date thereof 12/29/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Leonard J. Rucl
(b) Address 5305 Harford Road

19 (a) DEC 28 1945 (Date received by Registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 27th, 1945 at 5:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/6 1943 to 12/27 1945. and that I last saw h[illegible] alive on 12/27 1945.

Immediate cause of death: Chronic Pulmonary Tuberculosis — Duration 10 years

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thurston Cooper M. D.
Address 2201 Eutaw Place Date signed 12/28/45
Baltimore-17 Md.

G35672 — BALTIMORE CITY HEALTH DEPARTMENT — G35672 Registered No.

CERTIFICATE OF DEATH 1945

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2911 GLENMORE AVE.
(c) Hospital or institution: MERCY HOSPITAL - DEAD ON ARRIVAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 9 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2911 GLENMORE AVE. (If rural, give location)
(e) Citizen of foreign country? NOT OBTAINED (Yes or No)
If yes, name country

3 (a) FULL NAME MRS. EMMA E. MEIERS

3 (b) If veteran, name war:
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	W

6 (b) Name of husband or wife: William H.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 22, 1881

8. AGE:

Years	Months	Days	If less than one day
64	10	4	hr. min.

9. Birthplace Hartford Co. Md. (Town, county, and state)
10. Usual Occupation Housewife.
11. Industry or business HOME.

FATHER
12. Name Joseph Bramble
13. Birthplace Md.

MOTHER
14. Maiden Name Erwin
15. Birthplace Md.

16 (a) Informant MISS HILLIARD MEIERS
(b) Address 2911 Glenmore Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-29-45 (month) (day) (year)
(c) Cemetery or crematory Friendship
Location Belair

18 (a) Funeral director Leonard J. Fleig
(b) Address 5305 Harford Road

19 (a) DEC 28 1945 (Date rec'd by registrar) (b) Huntington Pittsville, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 26 1945 at 4 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from PATIENT 19 to DEAD ON ARRIVAL 19, and that I last saw h alive on 19.

Immediate cause of death PROBABLE CORONARY THROMBOSIS & Embolism. — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature John A. Hedrick M. D.
Address Mercy Hospital Date signed 12/26/45

G35673

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. G35673

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto. City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3172 Remington Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Sadie Tracey

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	wh.	widowed.

6 (b) Name of husband ~~or wife~~ Henry Milton Tracey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1 - 14 - ~~(Corr)~~ 1890

8. AGE: Years	Months	Days	If less than one day
55 (65)	8	12	hr. min.

9. Birthplace Baltimore - Md.
(Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name Charles M Egner
13. Birthplace Germany

MOTHER
14. Maiden Name Katherine Remeck
15. Birthplace Baltimore

16 (a) Informant Harry M Tracey (Son)
(b) Address 3172 Remington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-29-45 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Balto.

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Rd.

19 (a) DEC 28 1945 (Date rec'd by registrar)
Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec - 26 - 1945, at 40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec - 25 - 1945 to Dec - 26 1945, and that I last saw h.r. alive on Dec - 26 - 1945

Immediate cause of death Pneumonia
Pulmonary Edema
Hypertensive C-V Dis

Duration

Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George M Eshleman M. D.
Address
Date signed 12/28/45

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

635674

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. 635674

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp. 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) Died
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 504 S. Dallas St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country SARKA

3 (a) FULL NAME Andrew Syarek (Sarka)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
White	Male	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name —
13. Birthplace Poland

MOTHER
14. Maiden Name
15. Birthplace Poland

16 (a) Informant Julia Ruzyla
(b) Address 2529 Fleet St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-29-44 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location City

18 (a) Funeral director Wm. J. Fialkowski
(b) Address 2007 Eastern Ave

19 (a) DEC 28 1945 (Date rec'd by registrar) (b) Lurlyn Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 27, 1945 at 1:15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy/Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. Graham M.D.
Medical Examiner.
Date signed 12/27/45

G35675

BALTIMORE CITY HEALTH DEPARTMENT X
CERTIFICATE OF DEATH √ 124 B

Registered No. G35675

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Redwood & Green Sts
(b) Street address [redacted]
(c) Hospital or institution:
Univ Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 6 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Howard
(c) City or town Ellicott City
(If outside city or town limits, write RURAL and give town)
(d) Street No. Mercer St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country —

3 (a) FULL NAME William Dent

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: M
5. Color or race: N
6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife unknown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 2, 1890

8. AGE: Years 55 | Months 4 | Days 23 | If less than one day — hr. — min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Odd jobs
11. Industry or business —

FATHER
12. Name Jerry Dent
13. Birthplace [redacted] Md.

MOTHER
14. Maiden Name Jane Butler
15. Birthplace Md.

16 (a) Informant Alice Newson
(b) Address Ellicott City Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-30-45 (month) (day) (year)
(c) Cemetery or crematory Western Star
Location Baltimore Md

18 (a) Funeral director H.C. Hyde Interstate
(b) Address Ellicott City Md

DEC 28 1945 (Date received by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/25-1945, at 4 00 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/19/45 19— to 12/25-19 45, and that I last saw him alive on 12/25-19 45-

	Duration
Immediate cause of death Liver failure	
Due to Hepatic cirrhosis	
Due to Esophageal varices	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 12/13/45- Paracentesis
Major findings of operation: Cirrhosis, marked
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature]
Address Univ. Hosp. Date signed 12/28/45 M. D.

X

635676

635676

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1191a

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write age if especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Howard
(c) City or town Daniels
(If outside city or town limits, write RURAL and give town)
(d) Street No. Route # 4 9
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Church. ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12 - 0 - 45

8. AGE: Years	Months	Days	If less than one day
0	0	23 24	hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Meryl Talman
13. Birthplace Wva.

MOTHER
14. Maiden Name Isabelle Church
15. Birthplace Wva.

16 (a) Informant Isabelle Church
(b) Address Daniels Md.

17 (a) Burial (b) Date thereof 12-28-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Good Shepherd
Location Ellicott City Md.

18 (a) Funeral director P. C. Dysinteron
(b) Address Ellicott City Md

19 (c) DEC 28 1945 Huntington Williams Mgr
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 - 27 1945, at 4 15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-8 1945 to 12-28 1945, and that I last saw h.s alive on 12-27 1945

Immediate cause of death	Acidosis	Duration
Due to	Diarrhea	
Due to		
Other Conditions		

(Include pregnancy within 3 months of death)
Date of operation 0
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George R. Callender Univ. Hospital M. D.
Address 12-29-45 Date signed
Redwood & Eutaw Sts. Balt. MD. X

VS 150

635677

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. 635677

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Penalty for wilful misstatement or omission of any item or for any unauthorized alteration, $100 fine or imprisonment, or both, in addition to any penalty provided by law for perjury. [illegible]

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1534 N. Caroline Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-9
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1534 N. Caroline Stree
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZABETH ANNA MOXLEY

3 (b) If veteran, name war: NO
3 (c) Social Security Account No. NO

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife George Walet Moxley
6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) June 5, 1873

8. AGE: Years	Months	Days	If less than one day
72	6	21	....hr. ....min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William Schilpp
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mr. George Moxley
(b) Address 1534 N. Caroline Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-28-45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

DEC 28 1945 (Date received by registrar) (b) Huntington Willis, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 23 1945, at 11 A M
21. I certify that death occurred on the date above stated; that I attended deceased from ....19...., to ....19....,
and that I last saw h.... alive on ....19....

Immediate cause of death: Hypostatic pneumonia — Duration: 1 or

Due to: Bed sores

Due to: Senility

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide?
(b) Date of occurrence ....at .... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:
23. Signature Dr. J. Phillips
Address 1534 N. Caroline St. Date signed 12-26-45 M. D.

635678

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1108

635678 Registered No.

Please answer all questions in ink. Be sure the cause of death is clearly and legibly stated. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 845 N. Luzerne Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 845 N. Luzerne Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAROSLAV R. CIHLAR

3 (b) If veteran, name war: no.
3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of ~~husband~~ or wife Bohumila (nee Taborsky
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 21, 1884

8. AGE: Years	Months	Days	If less than one day
61 yrs.	8	3	hr. min.

9. Birthplace Czechoslovakia
(Town, county, and state)
10. Usual Occupation
11. Industry or business Own Business

FATHER
12. Name Antonin Cihlar
13. Birthplace Czech.

MOTHER
14. Maiden Name ~~Unknown~~ ANNA ROSOVA.
15. Birthplace Czechoslovakia.

16 (a) Informant Anthony Cihlar - brother
(b) Address 2627 Grogan Avenue

17 (a) Cremation (b) Date thereof 12/28/45
(Burial, cremation, or removal) (month) (day) (year)
(c) ~~Cemetery~~ or crematory Greenmount
Location Greenmount & Oliver, Balto. Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street

DEC 28 1945 (b) Huntington Williams M.D.
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 24 1945, at 9 15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from DEC 21 1945 to DEC 24 1945, and that I last saw h~~im~~ alive on Dec 24 1945

Immediate cause of death: Acute Cardiac Dil. Vavion — Duration 12/24/45
Due to Lobar Pneumonia — 12/20/45
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. J. Rypanek
Address 801 N. Kenwood Ave. Date signed 12/26/45 M.D.
Rypanek X

535679

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. 535679

Please write the causes of death clearly and legibly. Physicians: please write the correct age as accurately important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2616 E. Monument Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2616 E. Monument Street (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPHINE SEVCIK

3 (b) If veteran, name war: no
3 (c) Social Security Account No. none

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Emanuel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 21, 1869

8. AGE: Years 76 yrs. | Months 3 | Days 5 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Frank Svec
13. Birthplace Czechoslovakia

MOTHER
14. Maiden Name Barbara Panuska
15. Birthplace Czechoslovakia

16 (a) Informant Emanuel Sevick
(b) Address 2616 E. Monument St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/29/45 (month) (day) (year)
(c) Cemetery or ~~Crematory~~ Oak Hill
Location Phila Rd. Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

19 (a) DEC 28 1945 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 26 1945, at 6 30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 23 1945, to Dec. 26 1945, and that I last saw h ER alive on Dec. 26 1945.

Immediate cause of death: Arteriosclerosis — Duration: ?
Due to: Coronary artery disease — 3 days.
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis F. Klimes M.D.
Address 2623 E. Monument Date signed 12/27/45

VS 150

635680 BALTIMORE CITY HEALTH DEPARTMENT 635680

CERTIFICATE OF DEATH

Registered No. 108

Please answer all questions in full. Where the answer is "None," so state. Where date is given, do not fail to give year. Where the exact information is not known, approximate as nearly as possible. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2508 Druid Hill Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Kathryn Leherter

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Married

6 (b) Name of husband or wife Alexander Leherter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 2nd 1910

8. AGE: Years	Months	Days	If less than one day
34 35	4	22	hr. min.

9. Birthplace Baltimore Md (town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

MOTHER / FATHER
12. Name Alfred Crawford
13. Birthplace Maryland
14. Maiden Name Elmore Hickerson
15. Birthplace Balto. Md

16 (a) Informant Clara Crawford
(b) Address 2508 Druid Hill Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof 12-28-45 (month) (day) (year)
(c) Cemetery or crematory Saint Peters
Location Reisterstown Md.

18 (a) Funeral director Winfield S. Geddis
(b) Address 2101 Mc Culloh St Balto Md

19 (a) DEC 28 1945 (b) Huntington Williams, M.D. Registrar

VS 150 by J.R. Davis - Thomas J. Anderson, M. D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 24 1945, at 7 50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 24 19__ to Dec 24 19 45; and that I last saw h.. alive on Dec 24 19 45.

Immediate cause of death	Duration
Pneumonia	
Due to	
Due to	
Other Conditions acidosis Leukopenia (Include pregnancy within 3 months of death)	over
Date of operation	
Major findings of operation: —	
of autopsy: —	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
Signature Samuel Wiseman M. D.
Address Univ. Hospital Date signed 12-28-45

X

635681

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

635681 Registered No.

Please write the causes of death clearly and legibly. Correct age is especially important. Physicians: please write your name plainly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 10 da.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2957 Cornwall Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl McNamara

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	S.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 27, 1945

8. AGE: Years	Months	Days	If less than one day
			hr. 10 min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name John McNamara
13. Birthplace Balto Md.

MOTHER
14. Maiden Name Margaret Connolly
15. Birthplace Phila. Pa

16 (a) Informant Mother
(b) Address 2957 Cornwall Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-29-45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto Md

18 (a) Funeral director John A. Flaherty
(b) Address Fulton & Fayette

19 (a) DEC 29 1945 Huntington Willis, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 27, 1945, at 10:05 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 27, 1945 to Dec 27 1945 and that I last saw her alive on Dec 27 1945

Immediate cause of death	Duration
Failure to Breath.	
Due to Premature birth & Immaturity	
Due to 6 mo. fetus.	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Vincent O'Fitzpatrick Jr. M. D.
Address Mercy Hospital Date signed 12/28/45

VS 150

G35682 — BALTIMORE CITY HEALTH DEPARTMENT — G35682

CERTIFICATE OF DEATH

94a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hosp 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 1624 Argyle Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles T. Adams

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col.	Married

6 (b) Name of husband or wife Elinor Adams
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 5, 1877

8. AGE: Years	Months	Days	If less than one day
68	11	21	hr. min.

9. Birthplace North Carolina (Town, county, and state)
10. Usual Occupation Janitor
11. Industry or business

FATHER
12. Name John Adams
13. Birthplace N.C.

MOTHER
14. Maiden Name —
15. Birthplace

16 (a) Informant Elinor Adams
(b) Address 1624 Argyle Ave.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-30-45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md.
18 (a) Funeral director Jos. H. Kelson
(b) Address 1313 Pennsylvania Ave
19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 26 1945, at 8:45 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed 12-26-45

VS 151

G35683

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 130

G35683 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ da
(e) Length of stay in Baltimore (yrs., mos., or days) 53 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 427 Merryman Lane
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Harriet Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 14 1873

8. AGE: Years 62 | Months 11 | Days 10 | If less than one day: 9 hr. 50 min.

9. Birthplace Catonsville Maryland
(Town, county, and state)

10. Usual Occupation Domestic Service

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace —

MOTHER
14. Maiden Name Unknown
15. Birthplace —

16 (a) Informant Raymond Anderson
(b) Address 427 Merryman Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/31/45 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md.

18 (a) Funeral director Geo. H. Nelson
(b) Address 1313 Pressman St

19 (a) DEC 28 1945 (Date rec'd by registrar) (b) Thurlow Weed Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 25 1945, at 9:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 24 1945, to Dec. 25 1945, and that I last saw h.e.r. alive on Dec. 24 1945.

	Duration
Immediate cause of death Uremia	
Due to Glomerulonephritis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. J. Woodland Jr. M. D.
Address Provident Hosp. Date signed 1-9-46

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G35684

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

G35684 Registered No. 3698

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 517 Gilmor St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) Dead on arr 19
(e) Length of stay in Baltimore (yrs., mos., or days) 18 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 517 Gilmor St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Ann Speaks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Married

6 (b) Name of husband or wife Alfred Speaks
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Feb 13 1888

8. AGE: Years	Months	Days	If less than one day
57	10	11	hr. min.

9. Birthplace Nassawadox Va
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business own home

FATHER
12. Name Harry Kellam
13. Birthplace Va

MOTHER
14. Maiden Name Rosina ?
15. Birthplace Va

16 (a) Informant Armenella Speaks
(b) Address 517 Gilmor St

17 (a) Burial (b) Date thereof Dec. 28 '45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) (b) Huntington Williams, M.D.
(Registrar's signature)

DEC 28 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-24-1945 at 10:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-15 1945 to 12-24-1945, and that I last saw he alive on 12-24-1945.

Immediate cause of death Myocarditis — Duration unknown

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank A. Saunders M.D.
Address 1029 N. Stricker Date signed 12-27-45

Please give age if apparently important. Physicians: please write the causes of death clearly and legibly.

G35685

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124 B

Registered No. G35685

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 302 S. Fremont Ave. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME George D. Stringfellow

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col.	Married

6 (b) Name of husband or wife. Esther Stringfellow
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 23, 1899

8. AGE: Years	Months	Days	If less than one day
46	8	1	hr. min.

9. Birthplace Chester, S. C. (Town, county, and state)
10. Usual Occupation.....
11. Industry or business.....

FATHER 12. Name George D. Stringfellow
13. Birthplace Chester, S. C.

MOTHER 14. Maiden Name Isabell
15. Birthplace Chester, S. C.

16 (a) Informant Mrs. Esther Stringfellow
(b) Address 302 S. Fremont Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 29, 45 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion
Location.....

18 (a) Funeral director Mrs. Katie R. William.
(b) Address 322 N. Schroeder St.

19 (a) DEC 28 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 24 / 1945, at 5:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Ruptured Esophageal Varices

Due to.....

Other Conditions Cirhosis of liver.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury.....at.....M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?.....While at work?.....
(d) Means of injury.....

23. Signature Howard J. Sheeran M.D. Medical Examiner.
Date signed 12-26-45

VS 151

G35686
3694s-1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

✓ G35686 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 51

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore. (If outside city or town limits, write RURAL and give town)
(d) Street No. 512 East St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ernest Marshall

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: black | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 9, 1884

8. AGE: Years 61 | Months 11 | Days 14 | If less than one day ..... hr. ..... min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Joseph Marshall
13. Birthplace Md.

MOTHER
14. Maiden Name Katie ?
15. Birthplace

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 28 45 (month) (day) (year)
(c) Cemetery or crematory Alboutus Memorial.
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder Ste.

19 (a) DEC 28 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 23 - 1945 at 6 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-25- 1945 to 12-23-1945 and that I last saw h alive on 12-23-1945

Immediate cause of death: cardiac failure — Duration: 20 hrs

Due to: CA of stomach

Due to:

Other Conditions: Aneurysm of aorta

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. Paul Huggins, M.D.
Address Johns Hopkins Date signed 23 Dec 45

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X

G35876.71

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 65B

G35087
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Florida (b) County
(c) City or town Micanopy
(If outside city or town limits, write RURAL and give town)
(d) Street No. Route 1
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Bertha R. Ramsey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife James P. Ramsey

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-10-95

8. AGE: Years 50 | Months 8. | Days 17 | If less than one day hr. min.

9. Birthplace Florida.
(Town, county, and state)

10. Usual Occupation Housewife.

11. Industry or business

FATHER
12. Name Henry Rosenberger
13. Birthplace Pa.

MOTHER
14. Maiden Name Hannah R. Schwenk
15. Birthplace Pa.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal - Burial (Burial, cremation, or removal) (b) Date thereof Dec. 28-1945 (month) (day) (year)

(c) Cemetery or crematory Gainesville
Location Gainesville Florida

18 (a) Funeral director Burgess Funeral Home
(b) Address 3631 Falls Road

19 (a) DEC 28 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 27, 1945 at 7.12 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 5th 1945 to Dec. 27 1945
and that I last saw her alive on Dec 27, 1945

	Duration
Immediate cause of death: Lobular Pneumonia	
Due to: URAEMIA - Adrenal Insufficiency	? 8mo
Due to: AMYLOID DISEASE	
Other Conditions: Cachexia, ascites, renal insufficiency. (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Laurel Duncan M.D.
Address Johns Hopkins Hosp. Date signed 12/27/45

VS 150

Be sure the causes of death clearly and legibly. Physicians, please write plainly.

G35688 BALTIMORE CITY HEALTH DEPARTMENT G35688
CERTIFICATE OF DEATH 937 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 508 E. 41st St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and name town)
(d) Street No. 508 E. 41st St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James B. Gaston
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept. 28 186
8. AGE: Years 80 | Months 23 | Days 29 | If less than one day hr. min.
9. Birthplace Balto. Co. Md. (Town, county, and State)
10. Usual Occupation Retired Lawyer
11. Industry or business
FATHER 12. Name Noval W. Gaston
13. Birthplace Balto. Co. Md.
MOTHER 14. Maiden Name Matt. Goff
15. Birthplace Penna.
16 (a) Informant Mrs. Wm. Bell
(b) Address 508 E. 41st St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 31-45 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Olivet & Greenmount
18 (a) Funeral director John G. Haban
(b) Address 4201 Greenmount Ave.
19 (a) DEC 28 1945 (Date rec'd by registrar) (b) Huntington Hill Registrar

MEDICAL CERTIFICATION
20. DATE OF DEATH Dec. 27- 1945 at 10:30 AM
21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 26, 1945 to Dec. 27 1945 and that I last saw him alive on Dec. 26, 1945

Immediate cause of death	Duration
(a) Coronary Thrombosis	1 day
Due to (b) Hypertension Cardio Vascular	5 yrs.
Due to (c) disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Wm. H. Pannebaker
Address 2740 St. Paul St. Date signed 12/28/45
X Pannebaker

Correct cause of death clearly important. Physicians: please write the causes of death clearly and legibly.

VS 150

G35689

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 B

G35689

Registered No.

1. PLACE OF DEATH: 3017 Frisby St.
(a) Baltimore City, Maryland
(b) Street address 3017 Frisby St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3017 Frisby St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Thomas Birmingham

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife Ada Birmingham

6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) Oct. 19, 1872

8. AGE: Years 73 | Months 2 | Days 8 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Paperhanger

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Ada Birmingham
(b) Address 3017 Frisby St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 31 1945 (month) (day) (year)
(c) Cemetery or crematory, Baltimore
Location Baltimore Md.

18 (a) Funeral director George Weber & Son
(b) Address 2503 Edmondson Ave.

19 (a) DEC 28 1945 (Date rec'd by registrar) (b) Thurlington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 27, 1945 at 7 20 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 7 1945, to Dec 26 1945, and that I last saw h alive on Dec 26 1945

Immediate cause of death
Cancer of Stomach
Endocarditis — Duration —

Due to —

Due to Hypostatic Congestion — 2 day

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work)
(e) Means of injury

23. Signature H. L. Duly M. D.
Address 817 Medical Arts Bldg Date signed Dec 28 1945

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

X

G35690

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G35690

Please write the causes of death clearly and legibly. Physicians: please ...

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2109 N. Calvert St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2109 N. Calvert St.
(e) Citizen of foreign country? (If rural give location) (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES WESLEY BOSWORTH

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Beatrice Bosworth
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 4, 1859

8. AGE: Years	Months	Days	If less than one day
86	2	22	hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation Health Inspector
11. Industry or business Balto. City Health Dept.

FATHER
12. Name Thomas Bosworth
13. Birthplace Balto.

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Beatrice Bosworth
(b) Address 2109 N. Calvert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/28/45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (Date rec'd by registrar) DEC 28 1945 Authority for Williams MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 26, 1945, at 6 20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6 mo 19 to 12/26 1945 and that I last saw him alive on 12/26 1945

Immediate cause of death — Duration

coronary deficiency — 6 days

Due to

arteriosclerosis — many yrs.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M. D.
Address 2020 E. Oliver Date signed 12/27/45

G35691

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 B

Registered No. G35691

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1630 N. Washington Street
(c) Hospital or institution:

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1630 N. Washington St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

3 (a) FULL NAME: Mazie Mary Ferguson

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Andrew Ferguson Sr
6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.): March 1st., 187?

8. AGE: Years 68 | Months 9 | Days 25 | If less than one day ######## min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)
10. Usual Occupation: At Home
11. Industry or business

FATHER
12. Name: Dellrimple Bouldin
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Elizabeth Harris
15. Birthplace: Baltimore, Md.

16 (a) Informant: Mrs. Mable Brewer-Daughter
(b) Address: 1630 N. Washington Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/29/45 (month) (day) (year)
(c) Cemetery or crematory: Oak Lawn
Location: Eastern Ave Balto; Co

18 (a) Funeral director: George J. Ruth, Inc.
(b) Address: 1735 Harford Avenue

DEC 28 1945 (Date received by Registrar) (Signature of Registrar)

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 26th., 1945, at 2 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1- 1945 to Dec 26- 1945, and that I last saw her alive on Dec 26- 1945.

Immediate cause of death: Acute Dilatation of Heart — Duration: 1 day
Due to: Mitral Stenosis — 2 yrs
Due to:
Other Conditions: Cerebro Sclerosis — 5 yrs

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: E. Gill Hall M. D.
Address: 1631 E North av Date signed: Dec 27-45

Write age if specially important. Physicians: please write the causes of death clearly and legibly.

635692

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 635692

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2217 Eastern Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2217 Eastern Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Marecki
3 (b) If veteran, name war
3 (c) Social Security Account No. 215-05-7343
4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Mary Marecki
6 (c) If wife, give age years
7. Birth date of deceased (mo., day, yr.) July 9 1893
8. AGE: Years 52 | Months 5 | Days 17 | If less than one day hr. min.
9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Sheet Metal Worker
11. Industry or business Henry L. Martin

FATHER
12. Name J. Marecki
13. Birthplace Poland ?

MOTHER
14. Maiden Name
15. Birthplace Poland

16 (a) Informant Mary Marecki
(b) Address 2217 Eastern Ave.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 31/45 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Baltimore
18 (a) Funeral director Fred W. Ozarowski
(b) Address 1900 Eastern Ave.
19 (a) DEC 28 1945 (Date rec'd by registrar) (b) Huntington Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 26 1945, at 9:00 a.m.
21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1 1944 to Dec. 26 1945, and that I last saw h~~s~~m alive on Dec. 26 1945.

	Duration
Immediate cause of death: Left Ventricular failure	2 days
Due to: Chronic Myo-Carditis	1 yr.
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Jeff L. Volentine
Address 1702 E. Broadway Date signed 12/28/45

VS 150

G35693

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G35693 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General 23

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5 East Hamburg
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME PETER GOTTLIEB

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Augusta Haug

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 21, 1869

8. AGE Years 76 | Months 6 | Days 5 | If less than one day hr. min.

9. Birthplace Italy.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

12. Name Joseph Lipi ?

13. Birthplace Ger.

14. Maiden Name

15. Birthplace

16 (a) Informant Mrs. Hugh O'Donnell

(b) Address 132 Johnson Sq.

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 12/29/45 (month) (day) (year)

(c) Cemetery or crematory Loudon Park.

Location Loudon Park Rd.

18 (a) Funeral director J. H. Casey

(b) Address 130 S. Fort Ave.

19 (a) 1945 (Date filed by registrar) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/26/45 19 5:20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature John R. Norris M.D.
Medical Examiner.

Date signed 12/29/45

Cimbolo ✓

G35694 BALTIMORE CITY HEALTH DEPARTMENT G35694

CERTIFICATE OF DEATH 108

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Oakland & Raynor
(c) Hospital or institution:
West Baltimore General Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mo 25 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3913 Park Heights Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Margaret C. Cimbalo ✓

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-09-3118

4. Sex Female | 5. Color or race white | 6 (a) Single, ~~married, widowed, or divorced~~

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 1 - 1910

8. AGE: Years 35 | Months 1 | Days 26 | If less than one day hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation Art Instructor

11. Industry or business

FATHER 12. Name Francesco Cimbolo

13. Birthplace Cefalu Italy

MOTHER 14. Maiden Name Rosa Cimino

15. Birthplace Cefalu Italy

16 (a) Informant Thomas Cimbolo

(b) Address 3913 Park Heights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 31-1945 (month) (day) (year)

(c) Cemetery or crematory New Cathedral Cem.

Location Old Frederick Rd.

18 (a) Funeral director Joseph Fraser Inc.

(b) Address 2013 Hanmount Ave

19 DEC 29 1945 (b) Thurlow Williams, M.D. Registrar

MEDICAL CERTIFICATION 30

20. DATE OF DEATH Dec 27 1945, at 4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-27 1945 to 12-27 1945, and that I last saw h alive on 12-27 1945.

Immediate cause of death Lobar pneumonia — Bilateral — Pneumococcus — Duration

Due to Pneumobilomycosis fulminans

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Bilateral pulmonary

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address West Baltimore General Hosp. Date signed 12-27-45

VS 150

G35695

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registration No. G35695

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Holland & Green
(c) Hospital or institution:
University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Annapolis
(If outside city or town limits, write RURAL and give town)
(d) Street No. 16 Cathedral St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William B. Johnson Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: Wh

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary E. Johnson

6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) 12/31/74

8. AGE: Years 70 | Months 11 | Days 20 | If less than one day 24 hr. min.

9. Birthplace Md. Annapolis Md.
(Town, county, and State)

10. Usual Occupation Retired Buck Master

11. Industry or business

FATHER
12. Name Wm. Benjamin Johnson
13. Birthplace Md.

MOTHER
14. Maiden Name Mary E. Smith
15. Birthplace Md.

16 (a) Informant Mary E. Johnson
(b) Address Annapolis Md.

17 (a) Burial (b) Date thereof 12/31/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Annapolis Md

18 (a) Funeral director E. W. Lamasney
(b) Address 660 W. Baltimore St

DEC 28 1945
(Date rec'd by registrar)

Washington for Williams & Myers

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-28 1945, at 10:AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-27 1945 to 12-28 1945, and that I last saw h[illegible] alive on 12-28 1945.

Immediate cause of death	Duration
Cardiac failure	
Due to Coronary occlusion	
Due to Hypertensive	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles L. Butler M. D.

Address univ. Hosp. Date signed 12-29-45

G35696 BALTIMORE CITY HEALTH DEPARTMENT ✓ G35696
CERTIFICATE OF DEATH 46E Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 W. 40th St.
(c) Hospital or institution: Home for Incurables 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 yrs. 3 mos. 14 da
(e) Length of stay in Baltimore (yrs., mos., or days) 6 yrs 5 mo

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 700 W. 40th St. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME Mary Anna Scholl

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 14, 1884

8. AGE: Years 61 69 yrs | Months | Days 12 da | If less than one day hr. min.

9. Birthplace Frederick Co. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name William Scholl
13. Birthplace Frederick Co. Md.

MOTHER
14. Maiden Name Elizabeth Wood
15. Birthplace Frederick Co. Md.

16 (a) Informant Home for Incurable records
(b) Address 700 W. 40th St. Baltimore, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 29-45 (month) (day) (year)
(c) Cemetery or crematory Glades
Location Frederick Co. Md.

18 (a) Funeral director Rev. A. Mohan
(b) Address 4261 Greenmount Ave

19 Dec 28 1945 Harrington Williams, M.D. Registrar

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH December 26 1945, at 10.16 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4.12 1940, to 12/26 1945, and that I last saw h alive on 12/26 1945.

Immediate cause of death Not stated — Carcinoma of the breast + pleura — Bilateral Effusion

	Duration
Due to Carcinoma of the Colon?	3 Months
	6 months
Due to Pneumonia Coronal Thrombosis	
Other Conditions Abrasion of Right Leg (Infected)	46 years

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Grafton Hergenger M. D.
Address 214 Medical Arts Bldg Date signed 12/27/45

X

G35697

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46a

G35697

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important. Certificate must be correctly supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
U.S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 51 days
(e) Length of stay in Baltimore (yrs., mos., or days) 51 days

2. USUAL RESIDENCE OF DECEASED:
(a) State DC (b) County
(c) City or town Washington
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4620 - 45th St. NW
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Garvey, Harry Edwin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 29, 1879

8. AGE: Years	Months	Days	If less than one day
66	6	28	hr. min.

9. Birthplace Chicago, Ill.
(Town, county, and state)
10. Usual Occupation Guard
11. Industry or business

FATHER
12. Name William Garvey
13. Birthplace ?

MOTHER
14. Maiden Name Delia Daily
15. Birthplace ?

16 (a) Informant Records
(b) Address US Marine Hospital, Balto, Md.

17 (a) Removal (b) Date thereof 12-28-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Washington, D.C.

18 (a) Funeral director W. W. Chambers Co.
(b) Address 3 [illegible] M. St. N.W. Wash. D.C.

DEC 28 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 27 1945, at 6:45P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 6 1945, to Dec. 27 1945, and that I last saw him alive on Dec. 27 1945

	Duration
Immediate cause of death Postoperative status, resection of esophagus for carcinoma	21 days
Due to Empyema, left chest	less than 21 days
Due to	
Other Conditions Puncture of spleen by thoracentesis needle and hemoperitoneum.	3 days

(Include pregnancy within 3 months of death)
Date of operation Gastrostomy 11/8/45
Major findings of operation:
of autopsy As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon
Address Clinical Director Date signed 12/28/45
US Marine Hospital, Balto, Md.

G35698

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 77c

G35698
Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the cause to which death is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 17 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2136 E. Federal st.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lawrence L. Roache

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife Catherine Roache
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/20/1899

8. AGE: Years	Months	Days	If less than one day
46	3	6	hr. min.

9. Birthplace England
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Philip Roaches
13. Birthplace Eng.

MOTHER 14. Maiden Name Elizabeth Robinson
15. Birthplace Eng.

16 (a) Informant Deceased - Previous Hosp. Adm.
(b) Address

17 (a) Burial (b) Date thereof 12-29-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn Mem.
Location Taylor, Md.

18 (a) Funeral director Clarence T. Hoffman
(b) Address 1639 Broadway

19 (a) DEC 28 1945 Hunting for Williams M.D.
(Date filed by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 26th 1945, at 6 30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3 P.M. 12/26 1945 to 6:30 P.M. 12/26 1945, and that I last saw h alive on 19

Immediate cause of death Alcoholism Acute — Duration several Days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Cause obvious

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chapman H. Binford M. D.
Address U.S. Marine Hosp. Date signed 12/27/45

VS 150

G35699

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G35699

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 538 Richwood.
(c) Hospital or institution: —

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 538 Richwood
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Virginia Woolard.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. ~~Sex~~ Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 7, 1887

8. AGE: Years 58 | Months 8 | Days 19 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore Md.
(Town, county, and State)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Edward Deal
13. Birthplace Balto. md

MOTHER
14. Maiden Name Emma V. Kleinley
15. Birthplace Balto md

16 (a) Informant Mrs. Hairs allegood
(b) Address 538 Richwood Ave

17 (a) Burial (b) Date thereof Dec 29-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loraine Cem.
Location Baltimore md

18 (a) Funeral director A. Reuley Slade
(b) Address 4907 York Road

19 (a) Dec 28 1945 (b) Huntington Williams Registrar
(Date received by registrar)

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 26 1945, at 5. P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1942 to Dec. 26 1945 and that I last saw her alive on Dec 26 1945

Immediate cause of death: Terminal pneumonia — Duration: 4 days

Due to: Myocarditis — 2 years

Due to: Diabetes Mellitus — 6 years or more

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles A. Boyd M.D.

Address 3812 Greenmount Ave Date signed Dec 28/45

G35700 BALTIMORE CITY HEALTH DEPARTMENT G35700
CERTIFICATE OF DEATH 937 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1117 Hollins St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1117 Hollins St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Miller
3 (b) If veteran, name war —
3 (c) Social Security Account No. None
4. Sex M.
5. Color or race W.
6 (a) Single, married, widowed, or divorced Widower
6 (b) Name of husband or wife Margaret Miller
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Feb. 17 1874
8. AGE: Years 71 Months 10 Days 16 If less than one day hr. min.
9. Birthplace Pittsburgh Pa. (Town, county, and state)
10. Usual Occupation Retired Steel Worker
11. Industry or business

FATHER
12. Name Not Known
13. Birthplace

MOTHER
14. Maiden Name Not Known
15. Birthplace

16 (a) Informant Harry Miller
(b) Address 1117 Hollins St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 17 - 45 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Baltimore, Md.
18 (a) Funeral director Thomas J. Kenny Inc
(b) Address 1600 Hollins St
(c) (Date rec'd by registrar) 12 28 1945 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION 140
20. DATE OF DEATH Dec. 28 1945, at 4 M
21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1944, to Dec 28 1945, and that I last saw him alive on Dec 22 1945.

Immediate cause of death	Duration
Cerebral Hemorrhage	10 hours
Due to Hypertension Cardio Vascular Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Albert Hermont M. D.
Address 1934 W Lillers Ave Date signed

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G35701 ✓ G35701

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 125a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd + Calvert Sts.
(c) Hospital or institution:
Union Memorial Hospital ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2117 Guilford Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Eleanor Louise Tremor

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 9, 1925

8. AGE: Years	Months	Days	If less than one day
20	5	18	hr. min.

9. Birthplace Pennsylvania — Revere
(Town, county, and state)
10. Usual Occupation House maid
11. Industry or business

FATHER
12. Name [illegible] Tremor
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Grace Sickles
15. Birthplace Pennsylvania

16 (a) Informant Mrs. Grace Sies
(b) Address Leinasering #1 - Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-1-46 (month) (day) (year)
(c) Cemetery or crematory Lafayette Mem...
Location Pa

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Rd.,

19 (a) [illegible] (b) DEC 28 1945 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 27, 1945, at 2:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 26, 1945 to Dec. 27, 1945, and that I last saw her alive on Dec. 27, 1945.

Immediate cause of death Acute Yellow Atrophy of Liver — Duration

Due to Unknown Cause

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul S. Cozine M. D.
Address U. M. Hospital Date signed 12-28-45

VS 150

X

Please write clearly and legibly. Physicians: please write the exact age is especially important.

G35702

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G35702 ✓ Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3702 W. Rogers ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3702 W. Rogers ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Wilbert H. Tracey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Mary A. Ruby

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 5, 1876

8. AGE: Years 69 | Months 1 | Days 21 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Merchant

11. Industry or business

FATHER
12. Name John E. Tracey
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah E. Wilhelm
15. Birthplace Md.

16 (a) Informant John E. Tracey
(b) Address 3702 W. Rogers ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/29/45 (month) (day) (year)
(c) Cemetery or crematory Forest Baptist Church
Location Near Hampstead, Md.

18 (a) Funeral director Harry H. Kittle
(b) Address 401 E Monument ave

19 Dec 28 1945 (b)
(Date rec'd by registrar) Registrar

Please write the causes of death clearly and legibly. Physicians: please write exact age in especially important.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 26 1945, 6.45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1945 to Dec. 26 1945 and that I last saw him alive on Dec 26 1945

Immediate cause of death: Chronic Nephritis — Duration: 1 Yr
Due to: Chronic Valvular Disease — 1 Yr
Due to: of Heart
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature F. C. Helm
Address 2747 W. Mon. Date signed 12/28/45 M. D.

Physician for Williams, M.D.

F. C. Helm

G35703
TN. 86635

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 12

G35703
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1- 10- 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 17 months

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 220 S. Eden St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hester Arp

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: William

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 25th 1915

8. AGE: Years 32 | Months 3 | Days 2 | If less than one day hr. min.

9. Birthplace Ga.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Robert Poe
13. Birthplace Ga.

MOTHER
14. Maiden Name Mary Rose
15. Birthplace Ga.

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 30 1945 (month) (day) (year)
(c) Cemetery or crematory St Mathias
Location Adamsville Md

18 (a) Funeral director Wendell Chipley
(b) Address 313 S Highland Ave Huntingdon Williamsport Md

19 (a) (b)
(Date rec'd by registrar)

DEC 28 1945
VS file 8

MEDICAL CERTIFICATION

20. DATE OF DEATH December 27th, 1945 at 6.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 25th 19 44 to 12-27-45 19 , and that I last saw h er alive on Dec. 27 19 45

Immediate cause of death: Pulmonary Tuberculosis — Duration: ?
Due to: Tuberculosis Peritonitis
Due to:
Other Conditions: Tuberculous Enteritis
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy: Not Post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert B. Copeland Jr.
Address Balt. City Hosp. Date signed 12/27/45

Write age if specially important. Physicians: please write the causes of death clearly and legibly.

GB5704

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G35704 Registered No.

Write the causes of death clearly and legibly. Physicians: please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fleming
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 Mos.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTIMORE
(c) City or town SPARROWS POINT
(If outside city or town limits, write RURAL and give town)
(d) Street No. 525 E STREET
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MILLER, MRS MARY

3 (b) If veteran, name war ?

3 (c) Social Security Account No. ?

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced. WIDOWED

6 (b) Name of husband or wife ISAAC MILLER

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10 | 5 | 1864

8. AGE: Years 81 | Months 2 | Days 18 | If less than one day hr. min.

9. Birthplace WILLIAMSPORT, PENNSYLVANIA
(Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER
12. Name NULL,
13. Birthplace UNKNOWN

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace UNKNOWN

16 (a) Informant MILLER, ARCHIE
(b) Address 525 E ST. SPARROWS PT.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 26 45 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave. Rd.

18 (a) Funeral director John F. Connolly
(b) Address 418 Eastern Ave. Essex

19 12 28 1945 Huntington Williams Registrar
(Date filed by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/23 1945, at 4:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from DEC 22 1945, to DEC 23 1945, and that I last saw her alive on 12/23 1945, 1 AM

Immediate cause of death MASSIVE PULMONARY HEMORRHAGE — Duration

Due to ARTERIOSCLEROSIS COMPLICATED BY

Due to LOBAR PNEUMONIA

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. O. Patterson M. D.
Address Church Home Hospital Date signed 12/23/45

VS 130 OVER

2 G35705

BALTIMORE CITY HEALTH DEPARTMENT X V G35705

CERTIFICATE OF DEATH 83a

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address BROADWAY & FAIRMOUNT
(c) Hospital or institution:
CHURCH HOME HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days) 18 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County BALTIMORE
(c) City or town SPARROWS POINT
(If outside city or town limits, write RURAL and give town)
(d) Street No. 303 E STREET
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME FULCHER, JAMES MINNIS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	MARRIED

6 (b) Name of husband or wife FULCHER, NAOMI

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/10/1887

8. AGE: Years	Months	Days	If less than one day
58	1	15	hr. min.

9. Birthplace KNOXVILLE, TENN.
(Town, county, and state)

10. Usual Occupation MACHINIST

11. Industry or business

FATHER
12. Name FULCHER, JAMES
13. Birthplace KNOXVILLE

MOTHER
14. Maiden Name BIBEE, AMANDA
15. Birthplace KNOXVILLE, TENN.

16 (a) Informant HAZELWOOD, MRS JAMES
(b) Address 7004 MORNINGTON RD, DUNDALK

17 (a) Burial (b) Date thereof Dec. 31-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Taylor Ave.

18 (a) Funeral director John J. Connelly
(b) Address 414 Eastern Ave. Essex

19 (a) (b)
(Signature of registrar) Registrar

DEC 28 1945

VS 130

Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/27 1945, at 10:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/25 1945 to 12/27 1945, and that I last saw h.im alive on 12/27 1945.

Immediate cause of death	Duration
BRONCHOPNEUMONIA	2 DAYS
Due to CEREBRAL APOPLEXY	3 DAYS
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation NONE

Major findings of operation:

of autopsy: NONE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.

Address Church Home Hospital Date signed 12/27/45

X

C35706

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

C35706 Registered No.

Please write the cause of death clearly and legibly. Use only black ink. Do not use typewriter. Abbreviations, if necessary, please write them out.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2717 Mosher St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2717 Mosher St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Estelle B. Thomas

3 (b) If veteran, name war: No
3 (c) Social Security Account No. 213-05-4047B

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Harry K.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 28, 1880

8. AGE: Years 65 | Months 3 | Days 29 | If less than one day hr. min.

9. Birthplace Philadelphia Pa
(City, county, and state)

10. Usual Occupation Bookkeeper

11. Industry or business Chesapeake Coal Co

FATHER
12. Name Unknown Harrod
13. Birthplace Pa

MOTHER
14. Maiden Name Rachel Emmert
15. Birthplace Baltimore Md

16 (a) Informant Dorothy M. Kelly
(b) Address 705 Richmond Parkway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/31/45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore Md

18 (a) Funeral director Oldham Bros Inc
(b) Address 1214 E Fayette St

DEC 29 1945 (Date rec'd by registrar) Registered by Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 27 1945, at 8:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1945 to Dec 27 1945 and that I last saw her alive on Dec 27 1945.

Immediate cause of death: Lobar pneumonia — Duration

Due to:

Due to:

Other Conditions: Arteriosclerosis Cerebrum over

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Grant W. Palen

Address 1738 Pop Ex St Date signed 12/30/45

VS 150

G35707

485589.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G35707

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 128 N. Chapel St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Joshua Watkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male.

5. Color or race: Black.

6 (a) Single, married, widowed, or divorced: ?

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-23-(63)1893

8. AGE: Years 52 (63) | Months 2 | Days 5 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Joshua Watkins

13. Birthplace Md

MOTHER 14. Maiden Name Mary Forrester

15. Birthplace Md.

16 (a) Informant Records.

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 1, 1946 (month) (day) (year)

(c) Cemetery or crematory Daniel Star Cem.

Location Galesville, Md.

18 (a) Funeral director T. A. Hardesty & Son

(b) Address Ga lesville, Md.

19 (a) DEC 29 1945 (Date received by local registrar) (b) Huntington Williams M. D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 25 1945, at 3.50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 22 1945 to Dec. 25 1945, and that I last saw him alive on Dec. 25 1945

Immediate cause of death	Duration
1 Cerebral Hemorrhage	
Due to	
Due to	
Other Conditions	

Chronic ulcer Sejunum

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: incomplete

of autopsy: Incomplete

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature F. D. Stephens M. D.

Address Johns Hopkins Hosp Date signed 12-29-45

Give the causes of death clearly and legibly. Physicians: please write plainly.

G35708

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

✓ G35708 Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33-S. Pulaski St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life!

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 33-S. Pulaski St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maryanna Burl.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female.	White.	divorced.

6 (b) Name of husband or wife Wick Burl.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May-15-1867.

8. AGE: Years	Months	Days	If less than one day
78	7	12	hr. min.

9. Birthplace Baltimore-Md.
(Town, county and state)
10. Usual Occupation House Wife—
11. Industry or business At home.

FATHER
12. Name Unknown.
13. Birthplace Unknown.

MOTHER
14. Maiden Name Unknown.
15. Birthplace Unknown.

16 (a) Informant Mrs. Elizabeth Robinson
(b) Address 33-S. Pulaski St.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Dec. 29/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Md.

18 (a) Funeral director Charles J. Delzell
(b) Address 505 N. Monroe St.

19 (a) (Date rec'd by registrar) (b) Registrar

DEC 29 1945 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH December 27, 1945, at 9.50 P.M.

21. I certify that death occured on the date above stated; that I attended deceased from Dec. 17. 1945, to Dec 27 1945, and that I last saw her alive on Dec 27 1945.

Immediate cause of death: starvation Acidosis — Duration

Due to Carcinoma of Rectum, Metastatic

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Nathan Rosen M. D.
Address 206 S. Gilmor St Date signed 12-29-45

X

635703 Belmont Road.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH (92)

Registered No. 635703

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 Cold Spring Lane
(c) Hospital or institution:
Cold Spring Nursing Home.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1314 Asbury Road.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minerva E. Sleeger.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. married.

6 (b) Name of husband or wife Charles F. Sleeger

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15, 1871

8. AGE: Years 74 | Months 7 | Days 12 | If less than one day hr. min.

9. Birthplace Maryland.
(Town, county, and state)

10. Usual Occupation none.

11. Industry or business

FATHER
12. Name Samuel Ruby.
13. Birthplace Maryland.

MOTHER
14. Maiden Name Amanda Snyder.
15. Birthplace Maryland.

16 (a) Informant Charles F. Sleeger. Hr
(b) Address 1314 Asbury Road.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 31/45 (month) (day) (year)

(c) Cemetery or ~~crematory~~ Lorraine Park.
Location

18 (a) Funeral director Chenoweth & Donovan
(b) Address 3615-17 Chestnut Ave.

19 (a) (b) Registrar

DEC 29 1945

Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH December 27 1945, at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1945, to Dec 27 1945, and that I last saw her alive on Dec 26 1945.

Immediate cause of death Valvular heart disease — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. N. Patterson M. D.
Address 2324 Reisterstown Rd Date signed 12/28/45

VS 150

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35710

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G35710 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: John Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dead
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 707 N. Eden St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Pettaway

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 10, 1903

8. AGE: Years 42 | Months 3 | Days 17 | If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name unknown
13. Birthplace "

MOTHER
14. Maiden Name unknown
15. Birthplace "

16 (a) Informant Helen Pearson
(b) Address 407 N. Eden st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/3/45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Bruntsy ave

19 (a) (b) Hunting for Williams M.D. Registrar

DEC 29 1945

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/27 1945 3:05 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Chas. Gabrinski M.D. Medical Examiner.
Date signed 12/27/45

G35711

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G35711 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Fleet St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 26 South Bond (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie (~~Smoot~~) V. White

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race Col.

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1888

8. AGE: Years 57 | Months | Days | If less than one day hr. min.

9. Birthplace Maryland (Town, county and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Viola Pinder
(b) Address 39 S Dallas St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/29/45 (month) (day) (year)
(c) Cemetery or crematory Laurel
Location

18 (a) Funeral director Elroy A. Wilson
(b) Address 1000 Brantley ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 151 DEC 29 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/26/45 19 ..., at M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John A. Davis M.D. Medical Examiner.
Date signed 12/29/45

X

AB- 97312

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47D

Registered No. G35715

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 5-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
2 City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 405 Colvin St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Frank Blair

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March ? 1893

8. AGE: Years 52 | Months 0 | Days ? | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Baltimore City Hospitals (Records)
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/31/45 (month) (day) (year)
(c) Cemetery or crematory Dust Calvary
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brandeley and

19 (a) (Date rec'd by registrar) (b) Registrar

DEC 29 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 26 1945, at 3.15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-15- 1945, to 12-26- 1945, and that I last saw him alive on 12-26 1945.

Immediate cause of death: Carcinoma of lung — Duration

I metastasis to liver & Spleen

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: none

of autopsy: None as above

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature T. P. Gerrigor M. D.
Address Baltimore City Hosp Date signed 12-27-45

PHYSICIAN

Underline the cause to which death should be charged statistically.

Correct age is essentially important. Physicians: please write the causes of death clearly and legibly.

G35713
JL - 97998

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 83B

G35713
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1228 Druid Hill Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Grey

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	?

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? ?

8. AGE: Years	Months	Days	If less than one day
65 ?	?	?	hr. min.

9. Birthplace ?
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-31-45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Adolphus Halstead

18 (a) Funeral director
(b) Address 918 Druid Hill Ave

19 DEC 29 1945 (Date received by registrar) Registrar M. D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 22 1945, at 8:50A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 21 1945 to Dec. 22 1945, and that I last saw h im alive on Dec. 22 1945.

Immediate cause of death	Duration
Cerebral Thrombosis	?
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: none
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature T. P. Jernigan M. D.
Address Baltimore City Hosp Date signed 12-26-45

Hunting for Will

X

VS 150

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35714
CWF-69815

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

83B

G35714
Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5- 1- 18-
(e) Length of stay in Baltimore (yrs., mos., or days) 31 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. No Home
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Theodore Chamberlain

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 30-1898

8. AGE: Years	Months	Days	If less than one day
47	0	27	hr. min.

9. Birthplace Virginia
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Wrighter Chamberlain
13. Birthplace Virginia

MOTHER
14. Maiden Name Jannie Coffin
15. Birthplace Virginia

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof 12-31-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave

19 (a) DEC 29 1945 Huntington Williams, M.D.
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 27 19 45 at 7:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 9 1940, to Dec. 27 1945, and that I last saw h. im alive on Dec. 27 1945.

Immediate cause of death	Duration
Bronchopneumonia	
Due to	
Cerebral Thrombosis	
Due to	
Other Conditions	
Pyelonephritis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: None
of autopsy: Bronchopneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

25. Signature T. B. Gervigon M. D.
Address Baltimore City Hosp. Date signed 12-28-45

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G35715 / 93D / Registered No. G35715

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1417 Cairo St
(c) Hospital or Institution Provident Hospital 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1417 Cairo St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Maggie Matthews

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years	Months	Days	If less than one day
67			hr. min.

9. Birthplace Calvert Co. Md. (Town, county, and state)

10. Usual Occupation unemployed

11. Industry or business

FATHER
12. Name unknown
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mary Wilks
(b) Address 1417 Cairo Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-1-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Adolphus Halstead
(b) Address 245 Druid Hill Ave

19 (a) (Date rec'd by registrar) (b) Registrar

DEC 29 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH 20 Dec 1945, at 6:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio Vascular disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
Means of injury

23. Signature William J. Fitzpatrick M.D.
Date signed 20 DEC '45 Medical Examiner

VS 151

G35716

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 195 B

G35716 Registered No.

Write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 114 E Oastend St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 - 5
(e) Length of stay in Baltimore (yrs., mos., or days) 39 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 114 E Oastend St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George · A · Poyner

3 (b) If veteran, name war No | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Rosalee Bell

6 (c) If alive, give age 32 years

7. Birth date of deceased (mo., day, yr.) Feb. 27, 1906

8. AGE: Years 39 | Months 10 | Days 1 | If less than one day ..... hr. ..... min.

9. Birthplace Maryland. (Town, county, and state)

10. Usual Occupation Laundry

11. Industry or business Laundry

FATHER 12. Name William Poyner

13. Birthplace N. C.

MOTHER 14. Maiden Name Millie Smith

15. Birthplace Maryland

16 (a) Informant Mrs. G. A. Poyner

(b) Address 114 E. Oastend St Balto. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 31 1945 (month) (day) (year)

(c) Cemetery or crematory Park [illegible] Md.

Location Brunswick Md.

18 (a) Funeral director C. H. Fe[illegible] & Bro

(b) Address Brunswick Md

19 (a) ..... (Date received by Registrar) (b) ..... Registrar

DEC 29 1945

Hunting for Mr. [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 27 1945 at 9.40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1945 to Dec 27 1945 and that I last saw him alive on 12/27 1945.

	Duration
Immediate cause of death Rheumatic Heart Disease	6 mos.
Due to	
Due to Rheumatic fever.	?
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Isaac Miller M.D. M. D.

Address 1124 N Pleasant St Date signed 12/28/45

X

G35717

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 a

G35717 Registered No.

Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address JOHNS HOPKINS HOSPITAL
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2109 Division St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Vance Sharp

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Isabelle Sharp

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-25-01

8. AGE: Years 44 | Months 2 | Days 2 | If less than one day hr. min.

9. Birthplace N. C. (Town, county, and state)

10. Usual Occupation

11. Industry or business Barber

FATHER
12. Name Samuel Sharp.
13. Birthplace N. C.

MOTHER
14. Maiden Name Elizabeth Arrington
15. Birthplace N. C.

16 (a) Informant JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/31/45 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location

18 (a) Funeral director Mrs. Robert A. Elliott & Daughter
(b) Address 1129 N. Carolina St

19 (a) (b)
Registrar

DEC 29 1945 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-27 1945 at 9½ a M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-30 1945 to 12-27 1945 and that I last saw h— alive on 12-27 1945

	Duration
Immediate cause of death: Cardiac Failure	1 Month
Due to: Hypertensive Cardio vascular disease	2 years
Due to: ? Chronic Glomerulo-nephritis.	?
Other Conditions: Coronary Occlusion Pulmonary Embolism	2 wks

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Cardiac Hypertrophy Pulmonary Embolism

of autopsy: Coronary Occlusion

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Freeman J Stephens M. D.
Address Johns Hopkins Hosp. Date signed 12-27

X

63578 BALTIMORE CITY HEALTH DEPARTMENT 63578

CERTIFICATE OF DEATH

Registered No. 178A

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 416 W. Pratt St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eugene Reynolds

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1899

8. AGE: Years	Months	Days	If less than one day
46			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 29 45 (month) (day) (year)

(c) Cemetery or crematory Baltimore Municipal

Location Frederick Road

18 (a) Funeral director O'Day Funeral Home Inc.

(b) Address 4644 York R.D

19 (a) Dec 29 1945 Huntington Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 24 1945 at 8:45 P. M.

21. I certify that I took charge of the remains described above, held an Partial autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation

Due to Carbon monoxide

Other Conditions Cirrhosis of liver, splenomegaly + Ascites

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 4/1

(a) Date of injury 12-24- at 5.30 P. M.

(b) Where did injury occur? 416 W. Pratt Street

(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no

(d) Means of injury Illuminating gas stove.

23. Signature Howard J. Cleveland M.D. Medical Examiner.

Date signed 12-26-45

VS 151

128

G35719 TAYLOR 937 G35719

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4201 Pennington Ave
(c) Hospital or institution: South Baltimore Gen. Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4201 Pennington Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Taylor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years 67 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) Burial (b) Date thereof Dec 29 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Methodist
Location Frederick Road

18 (a) Funeral director O'day Funeral Home Inc
(b) Address 4644 York Road.

DEC 29 1945
(Date received by Registrar)

(b) Huntington Williamsport, Md

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 21 Dec 1945, at 8:00 P M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio Vascular Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J Helpick M.D.
Medical Examiner.
Date signed 22 Dec 45

G35720

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

G35720 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Kelbourne & Caton Aves
(c) Hospital or institution: St Agnes Hospital 20
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 5
(If outside city or town limits, write RURAL and give town)
(d) Street No. 68 S. Monroe St.
(If rural, give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Hungary

3 (a) FULL NAME Mrs. Louise Seaman

3 (b) If veteran, name war None
3 (c) Social Security Account No. None

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-11-1865

8. AGE: Years 80 | Months 9 | Days 17 | If less than one day hr. min.

9. Birthplace Hungary (Town, county and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER 12. Name Joseph Orbit
13. Birthplace Hungary
MOTHER 14. Maiden Name Elizabeth Dengel
15. Birthplace Hungary

16 (a) Informant Mrs. Anna Bilf
(b) Address 618 S. Monroe St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-30-45 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md.

18 (a) Funeral director Geo. L. Schaub
(b) Address 2101 Frederick Ave.

19 DEC 29 1945 (Date received by registrar) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH December 28 1945, at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/27 1945 to 12/28 1945, and that I last saw he alive on 12/28 1945

Immediate cause of death	Duration
Cardio Resp Failure	
Due to Arteriosclerotic Heart Disease	
Due to	
Other Conditions Intestinal Obstruction Ca of Rectum (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. Elsi M
Address St Agnes Date signed 12/28/45

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

63572 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170c

Registered No. 63572 1

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5732 Railway Avenue (If rural give location)
(e) Citizen of foreign country? No. If so, of what country? Dundalk (Yes or No)
If yes, name country.....

3 (a) FULL NAME Lee Rohrer

3 (b) If veteran, name the war	3 (c) Social Security Account No.
None	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Elma Rohrer
6 (c) If alive, give age 32 years
7. Birth date of deceased (mo., day, yr.) January 15, 1904

8. AGE: Years	Months	Days	If less than one day
39	11	13	....hr. ....min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Electrician
11. Industry or business Bethlehem Steel
FATHER 12. Name Harry Rohrer
13. Birthplace Maryland
MOTHER 14. Maiden Name Clara Leatherman
15. Birthplace Maryland
16 (a) Informant Elma Rohrer
(b) Address 6732 Railway Ave.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-2-45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.
18 (a) Funeral director Geo. L. Lehnert
(b) Address 210 Frederick Ave
19 (a) DEC 29 1945 (Date rec'd by registrar) Huntington Nicholas, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 28, 1945 at 9 15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Skull fracture
intracranial hemorrhage
Due to.....
Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-25-45 1:05 A.M.
(b) Where did injury occur Loch Raven Blvd + Taylor Ave
(c) Did injury occur in home, on farm, industrial place, in public place? public While at work? no.
(d) Means of injury auto - & auto collision

23. Signature Benedict Skutarelis M.D. Medical Examiner.
Date signed 12-29-45

VS 151

G35722

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 161a

G35722
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1424
(c) Hospital or institution: Provident Hosp 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1424 Dawson St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ruth May Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-24-45

8. AGE: Years | Months | Days 3 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Quinten Brown
13. Birthplace Virginia

MOTHER
14. Maiden Name Lillian Bruton
15. Birthplace Va.

16 (a) Informant Quintan Brown
(b) Address 14x4 Division st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-31-45 (month) (day) (year)
(c) Cemetery or crematory Mt Alburn
Location Balto. Md.

18 (a) Funeral director William A. Jackson
(b) Address 916 Penna. Ave

19 DEC 29 1945 (Date received by registrar) Huntington Williams, Md. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 29 Dec 1945, at 3:20 M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Atelectasis Neonatorum

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William A Jackson M.D.
Medical Examiner.
Date signed 29 Dec 45

G35723 George C. Travers G35723

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1626 W Franklin
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1626 W Franklin (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George C Travers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	C	married.

6 (b) Name of husband or wife Bertha
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 6 1888

8. AGE: Years	Months	Days	If less than one day
57	9	20	hr. min.

9. Birthplace Cambridge, Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Charles Travers
13. Birthplace Cambridge Md.

MOTHER
14. Maiden Name Dorothy Todd
15. Birthplace Cambridge Md.

16 (a) Informant Bertha Travers
(b) Address 1626 W. Franklin St.

17 (a) Burial (b) Date thereof Dec. 30 45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N Schroeder St.

DEC 29 1945 (b) Huntingtown Williams, MD
(Date received by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 26 1945, at 7:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 23 19 45, to Dec 26 19 45, and that I last saw h[im] alive on Dec 26 19 45.

Immediate cause of death

Due to Congestion of Lungs

Due to Pneumonia

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
6 hrs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Date signed 12/29/45

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35724 G35724

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1504 W. Franklin St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1504 W. Franklin St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Samuel Bailey, Sr

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Martha

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1878

8. AGE: Years 67 | Months 9 | Days | If less than one day hr. min.

9. Birthplace Newport News, Va. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Thomas Bailey
13. Birthplace Serva Co., Virginia

MOTHER
14. Maiden Name Hannah
15. Birthplace Serva Co., Virginia

16 (a) Informant Mrs. Samuel Bailey
(b) Address 1020 W. Lafayette Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 29 '45 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 3727 Schroeder St

19 (a) DEC 29 1945 (b) (Date rec'd by registrar) Registrar

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 25 1945 at 9 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 20 1945 to Dec. 25 1945, and that I last saw h/h alive on Dec. 25 1945

Immediate cause of death: Congestive Heart Failure — Duration: 2 weeks
Due to Arteriosclerotic Heart Disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. W. Dent Huntington Williams M.D.
Address 416 N. Johns St Date signed 12-29-45

X

G35725 HENRAHAN G35725

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 180

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp 5th
(d) Length of stay in hospital or inst. (yrs., mos., or days) dea
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 530 Hubbard alley
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Henrahan

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col.	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1862

8. AGE: Years	Months	Days	If less than one day
63			hr. min.

9. Birthplace Greenville N.C.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name John Henrahan
13. Birthplace N.C.

MOTHER
14. Maiden Name Judy Fields
15. Birthplace N. C.

16 (a) Informant Fannie Henrahan 80
(b) Address 1307 E. Monument St

17 (a) Buried (b) Date thereof 12/29/43
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location B. C. County, Md.

18 (a) Funeral director Joseph B. Locke & Co.
(b) Address 1307 N. Central Ave
(c) Registered by (b) Huntington Williams M.D.
DEC 29 1945
(Date received by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 25. 1945, at 2 35 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Shock

Due to

Other Conditions 27-3rd degree burns.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12/25/45 5 P.M. 5/1
(b) Where did injury occur? 530 Hubbard alley
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no
(d) Means of injury conflagration.

23. Signature Howard J. Oberdeer M.D.
Medical Examiner.
Date signed 12-25-45

VS 151

G357126

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1160a

371813 G357126
Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: The Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3208 Berkshire Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bloodgood (Joseph Holt Bloodgood Jr)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 28, 1945

8. AGE: Years | Months | Days | If less than one day hr. 2 min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joseph H. Bloodgood
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Isabel Brown
15. Birthplace Maryland

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/29/45 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore, Md.

18 (a) Funeral director H. W. Meairston
(b) Address 8 E. N. Calvert St.

DEC 29 1945
(Date rec'd by registrar) (b) Washington for Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 28 1945, at 12:04 AM

21. I certify that death occurred on the date above stated; that I attended deceased from December 28 1945 to December 28 1945, and that I last saw him alive on December 28 1945.

Immediate cause of death	Duration
? intracranial hemorrhage	
? asphyxia	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature Gilbert J. Vosburgh M. D.
Address Johns Hopkins Hosp. Date signed 12-28-45

G35727

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G35727

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution: Maryland General Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2224 W. North Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANN LILLIAN BILLUPS

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Dr. Gaius W. Billups
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 5, 1888

8. AGE: Years	Months	Days	If less than one day
57	5	23	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Joseph Shimek
13. Birthplace Baltimore

MOTHER
14. Maiden Name Josephine Novak
15. Birthplace Austria

16 (a) Informant Dr. G. W. Billups
(b) Address 2224 W. North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/31/45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

(Date received by Registrar) (b) Huntingtown Williamsport, Md.

DEC 29 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/28 1945; at 12:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/15 1945; to 12/28 1945; and that I last saw her alive on 12/28 1945.

Immediate cause of death	Duration
Terminal Pneumonia	
Due to Metastatic Carcinoma Breast (Spine, lungs, possibly brain)	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Martin E. Strobel M. D.
Address Md. Gen. Hospital Date signed 12/29/45

G357?28

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G357?28 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 W. 40th St.
(c) Hospital or institution:
Home For Incurables. 13
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs. 11 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 700 W. 40th St.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Florence Sybil Bender.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Lewis H. Bender.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 26, 1857

8. AGE: Years 88 | Months 11 | Days 12 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Daniel Derr.
13. Birthplace Frederick, Md.

MOTHER 14. Maiden Name Rachel Altvater.
15. Birthplace Frederick Co., Md.

16 (a) Informant Home for Incurables Records.
(b) Address 700 W. 40th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/31/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by Registrar) (b) Huntington Wills Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 28 1945, at 8:10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3/10 1945 to 12/28 1945, and that I last saw h.... alive on 12/27 1945.

	Duration
Immediate cause of death Coronary Occlusion	4 Days
Due to Hypertensive Cardio-Renal Vascular Disease	18 years
Due to Arteriosclerosis (Generalized)	25 years
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Grafton Hergesheimer M. D.
Address 714 Medical Arts Bldg. Date signed 12/29/45

VS 3

X

G357:29

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G357:29

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1711 E 29th St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-6

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1711 E 29th St. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME ALBERT VINTON DUCKETT

3 (b) If veteran, name war: None

3 (c) Social Security Account No. R. R. Retirement

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Rosetta E. Duckett

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 15, 1883

8. AGE: Years	Months	Days	If less than one day
62	4	12	..... hr. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual Occupation: Clerk

11. Industry or business: P. R. R.

FATHER
12. Name: Robert Duckett
13. Birthplace: Md.

MOTHER
14. Maiden Name:
15. Birthplace:

16 (a) Informant: Mrs. Rosetta E. Duckett
(b) Address: 1711 E. 29th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/31/45 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

DEC 29 1945

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 27 Dec 1945, at 7:05 M

21. I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest thereon and from the evidence obtained by said Inquest find that said deceased came to his death on the day stated above.

Immediate cause of death	Duration
Coronary Occlusion	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William J. Holland M.D. Medical Examiner.
Date signed 28 Dec 45

VS 6

~~35730~~

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. 35730

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1600 N. Caroline St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-9
(e) Length of stay in Baltimore (yrs., mos., or days) 35yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1600 N. Caroline St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Henry R. Ludemann

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-01-0806

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	widower

6 (b) Name of husband or wife Catherine R. Ludemann
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 20, 1876

8. AGE: Years	Months	Days	If less than one day
69	11	7	hr. min.

9. Birthplace Boston, Mass. (Town, county, and state)
10. Usual Occupation Produce worker
11. Industry or business Produce

FATHER 12. Name Henry Ludemann
13. Birthplace Mass.

MOTHER 14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mary A. Matthews
(b) Address 1829 N. Montford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 31, 1945 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore, Md.

18 (a) Funeral director Durward L. Covington
(b) Address 21 W. 25th St.

19 DEC 29 1945 (Date received by registrar) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 27 1945 at 5:35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/27 19 to 12/27 19 ; and that I last saw h[illegible] alive on 12/27 19 .

Immediate cause of death

Acute Carditis

Due to Rheumatism

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Williams M.D.
Address 733 Argyle St Date signed 12/28/45

VS 150

G35731

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G35731 Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden & Madison Ave
(c) Hospital or institution:
Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1622 E. 30th Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY ALBERTA (MOLLIE) CROSS

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	220-07-0332

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Fe	W.	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 6, 1871

8. AGE: Years	Months	Days	If less than one day
74	3	22	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation ~~Housewife~~ Sales lady
11. Industry or business Hochschild Kohn & Co.

FATHER
12. Name Edward Cross
13. Birthplace paltimore, Maryland

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mr. John E. Crawford
(b) Address 1622 E. 30th Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-31-45 (month) (day) (year)
(c) Cemetery or crematory BALTIMORE CEMETERY
Location BALTIMORE, MARYLAND

18 (a) Funeral director HENRY SANDER & SONS, inc.
(b) Address NORTH AVE. & BROADWAY

19 DEC 29 1945 (Date received by Registrar) Washington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 28 1945, at 8 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 27 1945, to Dec 29 1945, and that I last saw her alive on Dec 29 1945

Immediate cause of death	Duration
Subarachnoid hemorrhage	
Due to Hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature C. E. Jones, M.D.
Address Maryland General Hospital Date signed 12/29/45

G35732

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1944

Registered No. G35732

Please write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3032 St. Paul Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3032 St. Paul Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN SOMMERS

3 (b) If veteran, name war: No

3 (c) Social Security Account No. none

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Annie Sommers

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 20, 1873

8. AGE: Years 72 | Months 3 | Days 9 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Business

11. Industry or business Independent Wall Paper Co

FATHER
12. Name Mickel Sommers
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Smith
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. Annie Unbach
(b) Address 3032 St. Paul Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-31-45 (month) (day) (year)
(c) Cemetery or crematory Mount Carmel Cem
Location Baltimore, Maryland

18 (a) Funeral director HENRY SANDER & SONS, INC.
(b) Address NORTH AVE. & BROADWAY

19 (b) DEC 29 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 28 1945 at 11 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to Dec 28 1945, and that I last saw h— alive on — 19

Immediate cause of death Coronary occlusion. — Duration Instantly

Due to Arteriosclerosis

Due to

Other Conditions Myocardial failure
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John H. Fletcher

Address 1035 N. Calvert St. Date signed 12/29/45

Harlow for Williams, M.D.

VS 150

G85733

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G85733

1310a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2614 Washington Blvd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give county)
(d) Street No. 2614 Washington Blvd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mabel K. Braun

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Sebastian J. Braun

6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) Jan 22 1898

8. AGE: Years 47 | Months 11 | Days 26 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Gabel
13. Birthplace Md

MOTHER
14. Maiden Name
15. Birthplace Md

16 (a) Informant Sebastian J. Braun
(b) Address 2614 Washington Blvd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 29 Dec 45 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Baltimore, Md

18 (a) Funeral director A. B. Shipley Son
(b) Address 800 Eutaw Pl.

19 DEC 29 1945 (Date received by Registrar) Hunting for Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/26/1945, at 5:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 17 1945 to Dec 26 1945 and that I last saw h... alive on ... 19...

Immediate cause of death: Hypertensive cardio vascular Disease

Due to: Auricular fibrillation

Due to: Uremia

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
5
5 Days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edgar L. Miller

Address 2623 Wash Blvd Date signed 12/28/45 M.D.

Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

VS 150

G35734

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121

Registered No. G35734

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hospital 14-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 25 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Baltimore County Md.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1840 Division (If rural give location)
(e) Citizen of foreign country? ——— (Yes or No)
If yes, name country

3 (a) **FULL NAME** Samuel Roosevelt Whiting

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex M

5. Color or race N

6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Anna Whiting

6 (c) If alive, give age ——— years

7. Birth date of deceased (mo., day, yr.) 5-1-03

8. AGE: Years 42 | Months 6 | Days 26 | If less than one day hr. ——— min.

9. Birthplace Gloucester, Va (Town, county, and state)

10. Usual Occupation Carpenters helper

11. Industry or business

FATHER
12. Name Haskins Whiting
13. Birthplace Virginia

MOTHER
14. Maiden Name Nat Lamon
15. Birthplace

16 (a) Informant Wife Ann Whiting
(b) Address 1840 Division St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 29 1945 (month) (day) (year)
(c) Cemetery or crematory Family Lot
Location Gloucester Co. Va

18 (a) Funeral director Mrs. Lee H. Holland
(b) Address 1631 Druid Hill Ave

19 DEC 29 1945 Huntington Williams M.D. (Date received by registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-27 1945, at 10:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-19 1945 to 12-27 1945 and that I last saw him alive on 12-19 1945

Immediate cause of death Intestinal obstruction — Duration

Due to Paralytic ileus

Due to Operation for acute suppurative appendicitis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 12-19-45

Major findings of operation: Suppurative appendix

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ——— at ——— M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. L. White M. D.

Address 1514 Division St Date signed 12-29-45

G35735

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. G35735

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1900 Lanvale Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 10 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1900 Lanvale Ave
(If rural give location)
(e) If foreign born, how long in U. S. A.? — years

3 (a) FULL NAME Elizabeth Joynes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	married

6 (b) Name of husband or wife Joseph P Joynes
6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years	Months	Days	If less than one day
61			hr. min.

9. Birthplace Hancock, Md.
(Town, county, and state)
10. Usual Occupation School Teacher
11. Industry or business

FATHER
12. Name Joseph Cotiman
13. Birthplace Md

MOTHER
14. Maiden Name Rosetta Haywood
15. Birthplace Md

16 (a) Informant Joseph P Joynes
(b) Address 1900 Lanvale Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-30-45 (month) (day) (year)
(c) Cemetery or crematory Jamestown Md
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantley ave

19 DEC 29 1945 (Date rec'd by local reg.) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 26 1945, at 5:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 19 1945, to Dec 26 1945; and that I last saw he alive on Dec 26 1945

Immediate cause of death	Duration
Congestive Heart Failure	10 days
Due to Essential Hypertension	Undetermined
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry McDonald M. D.
Address 644 N Carey St Date signed 12/29/45

VS 2

635736

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

106 B Registered No. 635736

Type or use ink. Spelling is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Bon Secours Hospital
(c) Hospital or institution: Baltimore & Payson Sts.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 830 Abbott Court (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Agnes Ritter
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	M

6 (b) Name of husband or wife Howard J. Ritter
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 11, 1887

8. AGE: Years	Months	Days	If less than one day
56 yrs.	5	16	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business None

FATHER
12. Name Daniel Bitetle
13. Birthplace Baltimore

MOTHER
14. Maiden Name Margaret Landey
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Howard J. Ritter
(b) Address 830 Abbott Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 31 1945 (Month) (day) (year)
(c) Cemetery or crematory Holy Cross Cemetery
Location Harford Rd. at Brooklyn

18 (a) Funeral director Edward W. Cunliffe & Son
(b) Address 924 E. Eager St.

19 (a) Date received by Registrar DEC 29 1945 (b) Registrar Huntington Williams

VS-150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/27/1945, at 11:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-21-1945 to 12-27-1945 and that I last saw her alive on 12-27-1945

Immediate cause of death	Duration
Acute Pulmonary Edema	6 days.
Due to Bronchiectasis Chr., Severe	
Due to Essential Hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chas. Norton Jr. M. D.
Address Bon Secours Hosp. Date signed 12/27/45

X

G35737 G35737

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St
(c) Hospital or institution: St Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2915 Berwick ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Myrtle E. Wehner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	M married

6 (b) Name of husband or wife Gerard H.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 10 - 1898

8. AGE: Years	Months	Days	If less than one day
47	4	18	hr. min.

9. Birthplace Balto, Md
(Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name Walter F. Smith
13. Birthplace N.Y.

MOTHER
14. Maiden Name Mamie Potter
15. Birthplace Cumberland Md.

16 (a) Informant Mrs. Gerard H. Wehner
(b) Address 2915 Berwick Ave.

17 (a) Burial (b) Date thereof 12-31-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto.

18 (a) Funeral director Leonard J. Luck
(b) Address 5305 Harford Road.

19 (a) 1946 (b) Thomas J. Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-28 1945 at 10.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-27 1945 to 12-28 1945 and that I last saw her alive on 12-28 1945

Immediate cause of death	Duration
Cardio-Respiratory failure	
Due to Bronchio-Pneumonia	
Due to	
Other Conditions Probable cerebral vascular accident	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M.E. Robertson M. D.
Address St Josephs Hosp Date signed 12-28-45

VS 150

107

G35738

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

G35738 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address LEVINDALE HOME
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Levendale Home
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY BEARMAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 9, 1851

8. AGE: Years 94 | Months 11 | Days 20 | If less than one day hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER 12. Name Abraham Bearman

13. Birthplace Russia

MOTHER 14. Maiden Name Dena Freda Wilensky

15. Birthplace Russia

16 (a) Informant Mrs Louis S Goldbloom

(b) Address Belden Apts

17 (a) Burial (b) Date thereof Dec 30/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Balto Hebrew Cem

Location Blair Road

18 (a) Funeral director Sol Levinson & Bros

(b) Address 1124-26 W. North Ave

19 (a) 0 2945 (Date rec'd by registrar) Thurlington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-28-45 19 , at 6 25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 2 1943, to Dec 28 1945 and that I last saw h alive on Dec 28 1945

Immediate cause of death	Duration
Myocardial fibrosis	
Hypertension	
Due to arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H Edmund Levin M.D.

Address Levindale Date signed 12-28-45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G35739

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 901 Mc Henry St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 39 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 901 McHenry St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Zelda Jennie Bernstein

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Late Solomon
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan, 10. 1882

8. AGE: Years 63 | Months 11 | Days 18 | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation
11. Industry or business House Work

FATHER
12. Name Nachan Budker
13. Birthplace Russia

MOTHER
14. Maiden Name Esther S Barlash
15. Birthplace Russia

16 (a) Informant Mrs Rea Slusky
(b) Address 823 Lake Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec, 30, 1945 (month) (day) (year)
(c) Cemetery or crematory Baltimore Hebrew Cemetery
Location Belair Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) Date rec'd by registrar (b) Washington Williams, Registrar

DEC 30 1945

VS 150

MEDICAL CERTIFICATION 12.15

20. DATE OF DEATH December 28 1945, at A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 27 Dec 1945 to 28 Dec 1945 and that I last saw her alive on 27 Dec 1945.

Immediate cause of death: Cardiac, Decompensation
Arterio sclerotic heart Disease, Auricular fibrillation — Duration: 2 yrs. 1 yr.
Due to: Coronary artery sclerosis, — Duration: ?
Due to: Generalized Arteriosclerosis — Duration: ?
Other Conditions: Hypertension — Duration: ?
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert J. Plevra M. D.
Address 876 Wash. Blvd Date signed 28 Dec 1945

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35740 — BALTIMORE CITY HEALTH DEPARTMENT — G35740 Registered No.

CERTIFICATE OF DEATH 93D

Please write the causes of death clearly and legibly. Correct age is especially important. Physicians: please write carefully and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution: Monument & Rutland Ave 1511
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3331 Dolfield Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Yetta Rebecca Merican

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Samuel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 1881

8. AGE: Years	Months	Days	If less than one day
64			hr. min.

9. Birthplace Riga (Town, county, and state)

10. Usual Occupation

11. Industry or business House Work

FATHER
12. Name Louis Yaffe
13. Birthplace Russia

MOTHER
14. Maiden Name Esther Krieger
15. Birthplace Russia

16 (a) Informant Samuel Merican
(b) Address 3331 Dolfiel Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec, 30, 1945 (month) (day) (year)
(c) Cemetery or crematory Beth TfilOh Cemetery
Location Windsor Mill Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) Filed in my office (b) Douglas Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 27 1945 at 6:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 2 1945, to Dec 27 1945, and that I last saw her alive on Dec 27 1945.

Immediate cause of death	Duration
Cerebral hemorrhage	
Due to Hypertension Cardio-Vascular Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M. D.
Address Sinai Hospital Date signed 12/30/45

X

G35741 G35741

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1780 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland DOA
(b) Street address 401 N. Payson St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 401 N Payson St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine M Eberhardt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W.

6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Joseph A

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/24/878

8. AGE: Years 67 Months Days 4 If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name August A Hill

13. Birthplace Germany

MOTHER 14. Maiden Name Margaret A Vogt

15. Birthplace Maryland

16 (a) Informant J Frank Wennerth

(b) Address 401 N Payson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-31-45 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Baltimore Md

18 (a) Funeral director George A Lafey

(b) Address Fulton & Fayette

19 (a) 30 1945 (Registered by registrar) Huntington Williams, Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/28 19 45, at 4:20 P M

21. I certify that I took charge of the remains described above, hold an Inspection-Inquiry thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to hr death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Asphyxia, due to
Inhaling gas.

Due to

Other Conditions Insanity

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 12/28/45 at about 12th Month A.M. 20/1

(b) Where did injury occur? 401 N. Payson St

(c) Did injury occur at home, on farm, industrial place, in public place? at home While at work? No

(d) Means of injury Inhalation of gas fumes

23. Signature D. J. Pulaski M.D.
Medical Examiner.

Date signed 12/26/46

X

G35782 BALTIMORE CITY HEALTH DEPARTMENT G35782
CERTIFICATE OF DEATH 94-a Registered No.

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4327 Reisterstown Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4327 Reisterstown Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Israel Kotovsky
(b) If veteran, name war
3 (c) Social Security Account No. 213-20-7158

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Ida Kotovsky
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1890

8. AGE: Years	Months	Days	If less than one day
55			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business –

FATHER
12. Name Abraham –
13. Birthplace Russia

MOTHER
14. Maiden Name Raha –
15. Birthplace Russia

16 (a) Informant Ida Kotovsky
(b) Address 4327 Reis Rd
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-30-45 (month) (day) (year)
(c) Cemetery or crematory United Hebrew
Location Wash. Blvd.
18 (a) Funeral director Jacob Lewis Inc
(b) Address 1434 E. Baltimore St
DEC 30 1945 Huntington Williams, M.D. Registrar
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 29 1945, at 8 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 29 1945, to Dec 29 1945, and that I last saw h[illegible] alive on Dec 29 1945.

Immediate cause of death Coronary thrombosis — Duration 3 days.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Harry Abraham M.D.
Address 1911 W Lafayette Ave Date signed 12/29/45

X

G35743

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 61

G35743 Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St. Rutland Ave
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 207 N. Wolfe St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nathan Robd (Rohd)

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-01-6300

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Ella Rohd

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years 65 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Lith.
(Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER 12. Name Mirza -

13. Birthplace Lith.

MOTHER 14. Maiden Name Cecelia -

15. Birthplace Lith

16 (a) Informant Ella Rohd

(b) Address 207 N. Wolfe St

17 (a) Burial (b) Date thereof 12-30-45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory North Point - Herman Heights

Location

18 (a) Funeral director Jack Lewis Inc

(b) Address 1398 E. Balto. St

19 (a) DEC 31 1945 (b) Washington Williams M.D. Registrar
Date rec'd by registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-28 1945, at 6.00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-24 1945, to 12-28 1945, and that I last saw h alive on 12-28 1945.

	Duration
Immediate cause of death Cerebral Accident (? embolism left middle cerebral artery)	3 days.
Due to Arteriosclerotic Heart Disease with probable	3 years
Due to myocardial infarction	1 mo.
Diabetes mellitus	15 yrs
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Arnold Katz M.D.

Address Sinai Hosp Balt Md. Date signed 12-29-45

G35744 BALTIMORE CITY HEALTH DEPARTMENT G35744
CERTIFICATE OF DEATH 1121 Registered No.

Type or write the causes of death clearly and legibly. Physicians: please write the cause which started the chain of events resulting in death directly above the cause or causes, if any, which gave rise to it, and so on. The cause which started the chain of events resulting in death should be entered last.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St
(c) Hospital or institution: South Baltimore Gen. Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 62 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore, Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 1532 Hanover St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME FRED W. SCHMIDT (FRIED)

3 (b) If veteran, name war: Nil
3 (c) Social Security Account No.: No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife: Katherine Schmidt
6 (c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) Aug 6, 1860

8. AGE: Years	Months	Days	If less than one day
85	4	23	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Frederick W. Schmidt
13. Birthplace Germany

MOTHER
14. Maiden Name Dont Know
15. Birthplace Dont Know

16 (a) Informant Katherine Schmidt
(b) Address 1532 Hanover St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 31, 1945 (month) (day) (year)
(c) Cemetery or crematory Western Cemetery
Location Balto. Md.

18 (a) Funeral director C. J. Howard Evans
(b) Address 1400 So Charles St

30 1945 (Date rec'd by registrar) Hastings Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 29 1945, at 4 24 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 24 1945, to Dec 29 1945, and that I last saw h[illegible] alive on Dec 29 1945.

Immediate cause of death	Duration
Peritonitis	5 days
Due to Ruptured duodenal ulcer	5 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 12/25/1945
Major findings of operation: 1 Case
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John M. Blosom M.D.
Address 3 E. Read St Date signed 12/29/45

Gen. Hospital

VS 150

G35745 G35745

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93-P Registered No.

Please write the causes of death clearly and legibly. Exact age is especially important. Physicians: please write legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1831 McHenry Street
(c) Hospital or institution: *******
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1831 Mc Henry Street
(If rural, give location)
(e) Citizen of foreign country? ******* (Yes or No)
If yes, name country ******

3 (a) FULL NAME MARGARET BRISCOE

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Frank Briscoe
6 (c) If alive, give age: Dead years
7. Birth date of deceased (mo., day, yr.): 9 -2- 1862
8. AGE: Years 83 | Months 3 | Days 27 | If less than one day: ********** hr. ********** min.
9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business: At Home

FATHER
12. Name: Unknown
13. Birthplace: Maryland

MOTHER
14. Maiden Name: ? Gallagher
15. Birthplace: Maryland

16 (a) Informant: Mrs. Margaret Romm
(b) Address: 1831 Mc Henry Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Dec. 31/45 (month) (day) (year)
(c) Cemetery or crematory: New Cathederal
Location: Baltimore Maryland

18 (a) Funeral director: F.B.WIPPERT & SON
(b) Address: 1300 EUTAW PLACE

19 (a) Date received by registrar: DEC 30 1945 (b) Registrar: Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 28, 1945 at A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 5 1945 to Dec 28 1945 and that I last saw he alive on Dec 28 1945

Immediate cause of death: Arteriosclerotic Cardio-Vascular Disease — Duration

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:
23. Signature: Albert Scagnetti M. D.
Address: Lombard & Fulton Ave Signed Dec 29 45

X

G35746

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

83 G35746
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3823 Fait Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3823 Fait Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick Wm. Kuhn

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	216-06-0874

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Mary Kuhn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 12, 1895

8. AGE: Years	Months	Days	If less than one day
50	7	16	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Chauffuer
11. Industry or business

FATHER
12. Name John Kuhn
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth De'Boy
15. Birthplace Md.

16 (a) Informant Mrs. Mary Kuhn
(b) Address 3823 Fait Ave.

17 (a) Entombment (b) Date thereof Dec. 31/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Balto. Md.

18 (a) Funeral director Philip Henry Sons
(b) Address 2024 Orleans St.

19 (a) DEC 30 1945 (b)
(Date received by Registrar) Hunting for Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 28 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 26 1945 to Dec 28 1945 and that I last saw h-- alive on Dec 28 1945

Immediate cause of death: Cerebral Hemorrhage — Duration: 2 hrs
Due to: Hypertension — Duration: Dec 26 42
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature B. J. Stockman M. D.
Address 350 N Dallas Date signed

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

X

G35747

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1 31

G35747 Registered No.

Be sure the cause of death clearly and legibly. Correct age is especially important. Physicians: please write this

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 200 - E. Eager St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eva Brooks (EVA J. BROOK)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Harry Brook

6 (b) Name of husband or wife.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-19-92.

8. AGE: Years 53 | Months 10 | Days 11 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name John Steinmeyer
13. Birthplace Md.

MOTHER 14. Maiden Name Anna Harvey
15. Birthplace Md.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 31/45 (month) (day) (year)

(c) Cemetery or crematory Loudwood Lawn
Location Baltimore Philip Sterling & Sons

18 (a) Funeral director 2024 Orleans St
(b) Address

19 (a) [illegible] (b) Filed by registrar Williams Huntington Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-28 1945; at 11 30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-24 1945 to 12-28 1945; and that I last saw h-e alive on 12-28 1945.

Immediate cause of death	Duration
Uremia	
Due to renal insufficiency	
Due to hypertensive cardiovascular renal disease	25 years
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Green
Address Johns Hopkins Hospital Date signed M. 12/28/45

G35748

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G35748 Registered No.

Correct answers to the causes of death clearly and legibly. Physicians: please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1732 N. Bond Street
(c) Hospital or institution: 8

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1732 N. Bond Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Jennie Davis

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: John E. Davis
6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) March 5th 1875

8. AGE: Years	Months	Days	If less than one day
70	9	23	hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: Ferdinand Dittell
13. Birthplace: Germany

MOTHER
14. Maiden Name: Margaret Walter
15. Birthplace: Germany

16 (a) Informant: John Edward Davis
(b) Address: 1732 N. Bond Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/31/45 (month) (day) (year)
(c) Cemetery or crematory: Baltimore
Location: E. North Avenue

18 (a) Funeral director: George J. Ruth, Inc.
(b) Address: 1735 Harford Avenue

EC 1945 (a) 30 (b)
(Date received by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 28 1945, at 7 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 15 1945, to Dec 28 1945, and that I last saw h.w. alive on Dec 27 1945.

Immediate cause of death	Duration
Edema Lungs	1 day
Due to Chronic Myocarditis	4 yr.
Due to	
Other Conditions Arteriosclerosis	8 yr.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. Gill Hall M. D.
Address 1631 E North Ave Date signed Dec 28 45

X

G35749 BALTIMORE CITY HEALTH DEPARTMENT G35749
CERTIFICATE OF DEATH 93D
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1822 N. Bond Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1822 N. Bond Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ella ####### Lannon

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) August 23, 1865

8. AGE: Years	Months	Days	If less than one day
80	4	6	########## min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Terrance Lannon
13. Birthplace Ireland

MOTHER
14. Maiden Name Elizabeth Harding
15. Birthplace Ireland

16 (a) Informant Mrs. Marie Simms (Daughter
(b) Address 1822 N. Bond Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/2/46 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Edmondson Avenue

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

(c) Date received by registrar Jan 2 1946 Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH December 28, 1945 8 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 20- 1945 to Dec 29- 1946 and that I last saw h.er alive on Dec 28 1946 M

Immediate cause of death	Duration
Edema of Lungs	5 days
Due to Chronic Myocarditis	5 yrs
Due to	
Other Conditions Arterio-Sclerosis	10 yrs

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. Gill Hall M. D.
Address 1631 E. North Ave Date signed Dec 29-45

VS 180

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35750 G35750

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 193-D

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1035 Aisquith St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) 57 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1035 Aisquith St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country Germany

3 (a) FULL NAME Barbara Preller

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: John Preller

6 (c) If alive, give age: D years

7. Birth date of deceased (mo., day, yr.): May 3 1863

8. AGE: Years: 82 | Months: 7 | Days: 25 | If less than one day: ... hr. ... min.

9. Birthplace: Germany (Town, county, and state)

10. Usual occupation: Home

11. Industry or business:

FATHER
12. Name: Nicholas Schad
13. Birthplace: Germany

MOTHER
14. Maiden Name: Anna Marie Koenig
15. Birthplace: Germany

16 (a) Informant: Anna E. Preller
(b) Address: 1035 Aisquith St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/2/46 (month) (day) (year)
(c) Cemetery or crematory: Holy Redemer
Location: Belair Road

18 (a) Funeral director: George J. Ruth; Inc.
(b) Address: 1735 Harford Ave.

19 (a) ... (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 28 Dec 1945, at 11:20 M

21. I certify that I took charge of the remains described above, held an Inspection Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Cerebral Stroke Cardio-Vascular disease

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? ... While at work?
(d) Means of injury:

23. Signature: William J. Siefred M.D. Medical Examiner.
Date signed: 29 Dec '45

VS 151

G35751

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 108

G35751
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp. ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 6 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. ✓ (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 202 S. Regester St ✓
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Stawara ✓

3 (b) If veteran, name war: World War 2
3 (c) Social Security Account No. 381-70-8880

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Lorretta Stawara ✓
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 3 1912

8. AGE: Years 33 34 | Months 9 | Days 24 | If less than one day hr. min.

9. Birthplace: Poland
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Joseph Stawara
13. Birthplace Poland

MOTHER
14. Maiden Name Josephine Regula
15. Birthplace Poland

16 (a) Informant Mrs Lorretta Stawara
(b) Address 202 S. Regester Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-31-45 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem
Location Baltimore County

18 (a) Funeral director John M. Weber
(b) Address 401 Gr. Chester Ave Huntington Williams M.D.

DEC 30 1945 (Date rec'd by Registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 27 1945, at 1:45 A M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Lobar Pneumonia

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Dec. 27 1945

G35752

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G35752 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 Coldspring Lane
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2101 Coldspring Ln (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clara Fischer
3 (b) If veteran, name war No
3 (c) Social Security Account No. None
4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) ? 1879
8. AGE: Years 66 | Months | Days | If less than one day hr. min.
9. Birthplace Balto. (Town, county, and state)
10. Usual Occupation None
11. Industry or business
FATHER 12. Name Conrad Fischer
13. Birthplace Balto.
MOTHER 14. Maiden Name Regina Long
15. Birthplace Balto
16 (a) Informant Andrew Fischer
(b) Address 2901 Overland Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/31/45 (month) (day) (year)
(c) Cemetery or crematory H. Redeemer
Location Belair Rd.
18 (a) Funeral director M. M. E. Doepkes Sons
(b) Address Lombard & Eden Sts.
(a) (b)
DEC 31 1945 (Date rec'd by Registrar) Registrar
Huntington Hillcrest

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 28 1945 at 4:P M
21. I certify that death occurred on the date above stated; that I attended deceased from July 3 1944 to Dec 28 1945 and that I last saw her alive on Dec 28 1945
Immediate cause of death Chronic myocarditis — Duration
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature M. M. Cutterman
Address 2224 Reisterstown Rd Date signed 12/29/45 M. D.

VS 150

X

Cause age is especially important. Physicians: please write the causes of death clearly and legibly.

G35753

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 939

G35753 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 56 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 412 E. 24th St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Laura Holley.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-27-1889

8. AGE: Years 56 | Months 6 11 | Days 29 | If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Bland Saffer

13. Birthplace St Mary's Co. Md.

MOTHER 14. Maiden Name Amanda Mason

15. Birthplace St. Mary's Co. Md.

16 (a) Informant Edward Holley

(b) Address 412 E. 24th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 30, 1945 (month) (day) (year)

(c) Cemetery or crematory Arbutus Mem.

Location Baltimore Co. Md.

18 (a) Funeral director Wm. George H. Stellan

(b) Address 1631 Druid Hill Ave

19 (a) 1945 (Date rec'd by registrar) (b) Signature for Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-24 19 45 at 10:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-24 19 45 to 12-24 19 45 and that I last saw her alive on 12-24 19 45.

Immediate cause of death Cerebral Hemorrhage — Duration three days

Due to Hypertensive Cardiovascular Disease — Duration Hypertension 5 to 6 yrs

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Wm. J. Wardlaw M.D.

Address 2 E. Madison St. Date signed 12-29-45

635754

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 128

635754 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green Sts.
(c) Hospital or institution:
Univ. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 513 Burgundy St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Aretha Fontleroy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1903

8. AGE: Years	Months	Days	If less than one day
42			hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Junius Taylor
13. Birthplace Va.

MOTHER
14. Maiden Name Carrie Fontleroy
15. Birthplace Va.

16 (a) Informant John Waters
(b) Address 513 Burgundy St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/31/45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director James A. Hayes
(b) Address 142 W. Hoffman St.

19 DEC 31 1945 (Date received by local registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/28 1945, at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/8/45 19 to 12/28 1945 and that I last saw her alive on 12/29/45 1945.

Immediate cause of death Cardio-Resp. failure — Duration

Due to Pulmonal Stenosis

Due to Lympho-granuloma Venereum

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 11/4/45

Major findings of operation: Pulmonal Stenosis

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. M. Leas
Address Univ. Hosp. Date signed 12/30/45

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35755

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. 2097 G35755

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1204 Whatcoat St.
(c) Hospital or institution: 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) 50yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1204 Whatcoat St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joshua Thomas
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	married

6 (b) Name of husband or wife Mrs Catherine Thomas
6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) August 5, 1882

8. AGE: Years	Months	Days	If less than one day
63	4	19	hr. — min.

9. Birthplace Northumberland Co. Va
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business City of Baltimore

FATHER
12. Name John Thompson
13. Birthplace Va

MOTHER
14. Maiden Name Catherine Waddy
15. Birthplace Va

16 (a) Informant Mrs Catherine Thomas
(b) Address 1204 Whatcoat St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 31-1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Lion Cemetery
Location

18 (a) Funeral director Wm Brooks
(b) Address 1463 N. Carey St

19 (a) (Signature of registrar) Huntington Williams M.D.
(b) Date received DEC 31 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 — 27 — 1945 at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-24-1945 to 12-27-1945 and that I last saw him alive on 12-27-1945.

Immediate cause of death	Duration
Myocarditis	Confirm
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank A Saunders M. D.
Address 1029 N. Stricker St Date signed 12-29-45

X

635756

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 635756

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4649 Harcourt Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4649 Harcourt Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME G. Norman Penn

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-03-7506

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Anna A. Penn

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 17th 1887

8. AGE: Years 58 | Months 1 | Days 13 | If less than one day hr. min.

9. Birthplace Baltimore Co. Maryland (Town, county, and state)

10. Usual Occupation Clerical

11. Industry or business Md. Drydock

FATHER 12. Name James H. Penn

13. Birthplace Balto. Co. Maryland

MOTHER 14. Maiden Name Virginia Archolas

15. Birthplace Balto. Co. Maryland

16 (a) Informant Mrs. G. Norman Penn

(b) Address 4649 Harcourt Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/2/1946 (mo.) (day) (year)

(c) Cemetery or crematory Parkwood

Location Baltimore, Maryland

18 (a) Funeral director Lorraine Funeral Home

(b) Address 7401 Belair Road

DEC 31 1945 (Date received by local registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 30th 1945; at 9:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 29 1945 to Dec 30 1945, and that I last saw h[illegible] alive on Dec 29 1945

Immediate cause of death: Coronary Occlusion — Duration: 10 minutes

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None

of autopsy: No

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide No

(b) Date of occurrence at M

(c) Where did injury occur? None (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? None (Specify type of place) While at work?

(e) Means of injury None

23. Signature L. L. Cordy, M.D.

Address 5106 Harford Rd Date signed 12-31-45

VS 150

G35757

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

158

G35757 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Belmont & Green St.
(c) Hospital or institution: Univ. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. Park Grove Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FURTICK, SUSAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/1945

8. AGE: Years | Months 8 | Days | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Robt. W. Furtick
13. Birthplace Arkansas

MOTHER
14. Maiden Name Charleen Romines
15. Birthplace Indiana

16 (a) Informant Robt. W. Furtick
(b) Address Park Grove Ave. Catons. Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-31-45 (month) (day) (year)
(c) Cemetery or crematory St. Johns Cem.
Location Ellicott City Md

18 (a) Funeral director Harry H. Witzke
(b) Address 4101 Edmondson Ave

19 DEC 31 1945 Wilmington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/29 1945 3:53 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/24 1945 to 12/29 1945 and that I last saw her alive on 12/29 1945

Immediate cause of death RESP. FAIL. — Duration

Due to KERNICTERUS, MALNUTRITION, Dehydration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy 12/29/45

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas J. Bowes M. D.
Address Univ. Hosp. Date signed 12/29

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

635758

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

Registered No. 635758

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2014 Fleet Street
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore-31,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2014 Fleet Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helena Merriken

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-03-9404

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband ~~xxxx~~ Joseph Merriken
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 6, 1885

8. AGE: Years	Months	Days	If less than one day
60	6	22	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Lorek
13. Birthplace Poland

MOTHER
14. Maiden Name Mary Nawrocki
15. Birthplace Poland

16 (a) Informant Joseph Merriken
(b) Address 2014 Fleet Street

17 (a) Burial (b) Date thereof 1-2-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Rozary
Location Baltimore, Co Md

18 (a) Funeral director George A. Weber
(b) Address 705 South Ann Street

19 DEC 31 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 28th 1945, at 10.05 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 18 1945 to Dec. 28 1945 and that I last saw h. alive on Dec. 28 1945.

Immediate cause of death Cerebral Hemmorage — Duration: Unknown

Due to Hypertension

Due to

Other Conditions Hypertrophic dilated Heart.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Hall Tramwell M. D.
Address Lorraine & Harlem Date signed 12-29-45

832

G35759 11018

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH
125a

Registered No. G35759

Type or print in ink. Be sure age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lenox Hospital
(c) Hospital or institution: Lombard & Greene
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Middleton (Rural)
(If outside city or town limits, write RURAL and give town)
(d) Street No. Corbett Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Margaret Canova

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Vito Canova
6 (c) If alive, give age: 39 years
7. Birth date of deceased (mo., day, yr.): May 10, 1919
8. AGE: Years: 26 Months: 7 Days: 20 If less than one day: hr. min.
9. Birthplace: N.Y. City (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: John Walsh
13. Birthplace: Ireland

MOTHER
14. Maiden Name: Mary Kenney
15. Birthplace: Ireland

16 (a) Informant: Vito A. Canova
(b) Address: Middleton, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 3, 1946 (month) (day) (year)
(c) Cemetery or crematory St. Josephs
Location Texas, Md.

18 (a) Funeral director Landon M. Brooks
(b) Address Sparks, Md.

19 (a) DEC 31 1945 (Date received by registrar) (b) Huntingtown Williamsport Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 30 1945; at 9:26 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 27 1945 to Dec 30 1945 and that I last saw her alive on Dec 30 1945

Immediate cause of death: Respiratory Failure — Duration:

Due to: Acute Yellow atrophy

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Richard O Warner M. D.
Address: Lenox Hosp Date signed: 12/30/45

G35760

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 D

Registered No. G35760

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3027 Elm Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 D
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3027 Elm ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida J Ward.

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Franklin T Ward

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 5 - 1854

8. AGE: Years 91 | Months 2 | Days 23 | If less than one day hr. min.

9. Birthplace Guilford Howard Co. Md
(Town, county, and state)

10. Usual Occupation house

11. Industry or business

FATHER
12. Name John H Rowles
13. Birthplace unknown

MOTHER
14. Maiden Name Sarah E Duvall
15. Birthplace unknown

16 (a) Informant Mrs Assa H Ann
(b) Address 3027 Elm ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-31-45 (month) (day) (year)

(c) Cemetery or crematory Guilford
Location Guilford Station & Md

18 (a) Funeral director Frank H Seitz
(b) Address 8144 36 St

19 (a) DEC 31 1945 (Date rec'd by registrar) Signature for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 28 1945, at 3 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec / 1945, to Dec 27, 1945; and that I last saw h.. alive on Dec 26 1945.

	Duration
Immediate cause of death Myocardial Insufficiency	10 days
Due to Arteriosclerosis	20 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Arthur J Dance M. D.
Address 1001 W 36th St Date signed 12-29-45

VS 150

X

G35761

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G35761 Registered No.

Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 941 So Bayliss St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days) 50

2. USUAL RESIDENCE OF DECEASED:
(a) State ..... (b) County .....
(c) City or town Balto Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 941 So Bayliss St (If rural, give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Jamie Ferguson

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: Col
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Henry
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years 65 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Va (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Reuben Hunter
13. Birthplace Va

MOTHER
14. Maiden Name Judy Watkins
15. Birthplace Va

16 (a) Informant James Myers
(b) Address 936 Francis St Corner Pulaski

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 31-1945 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location A & Co Rd

18 (a) Funeral director Robt F Middleton
(b) Address 1515 McElderry St

19 (a) DEC 31 1945 Registered by [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 27 19 45, at 2 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 20 19 45 to Dec 27 19 45; and that I last saw h alive on Dec 27 19 45

Immediate cause of death	Duration
L Lobar Pneumonia	7 da
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? ..... (Specify type of place)
(e) Means of injury .....

23. Signature B. D. Haleth
Address 1715 Druid Pk Date signed 12/31/45

VS 150

G35762

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

938

G35762 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1700 Block E. Monument
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 314 Springdale ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Solomon Schapiro

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Bertha

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1873

8. AGE: Years 72 | Months 8 | Days | If less than one day hr. min.

9. Birthplace Austria
(Town, county, and state)

10. Usual Occupation Real Estate

11. Industry or business

FATHER
12. Name Osias Schapiro
13. Birthplace Austria

MOTHER
14. Maiden Name Rebecca
15. Birthplace Austria

16 (a) Informant Joseph Schapiro
(b) Address 3405 Springdale ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/31/45 (month) (day) (year)
(c) Cemetery or crematory Beth Tfiloh Cong
Location Windsor Mill Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-26 W. North ave

19 DEC 31 1945 (Date received by registrar) (b) Interring for Williamsport, Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/30 1945, at 4201 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/27 1945 to 12/30 1945, and that I last saw h[im] alive on 12/30 1945

	Duration
Immediate cause of death Cardio-respiratory failure	
Due to arteriosclerotic heart disease	
Due to & cerebro-vascular accident	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Marvin Kuhn M. D.

Address Sinai Hosp Date signed 12/30/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly

G35763

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G35763

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2920 Parkwood ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2920 Parkwood ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Pomerantz

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. —

4. Sex male

5. Color or race white

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Esther

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1890

8. AGE: Years 55 | Months | Days | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business Merchant

FATHER
12. Name Jacob Pomerantz
13. Birthplace Russia

MOTHER
14. Maiden Name Frieda
15. Birthplace Russia

16 (a) Informant Esther Pomerantz
(b) Address 2920 Parkwood ave

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Dec 31 1945 (month) (day) (year)
(c) Cemetery or crematory Hebrew Herring Run
Location Bowley Lane + Philia Rd

18 (a) Funeral director Sol Levinson + Bros
(b) Address 1124-26 W. North ave

19 (d) DEC 31 1945 Huntington Williams, M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 30 1945 at 10:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 10 1945 to 12/29 1945 and that I last saw h. alive on 12/29 1945.

Immediate cause of death Acute Coronary infarction — Duration

Due to Coronary Sclerosis

Due to hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Huntington Williams

Address 733 Argonette Av Date signed 12/30/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G35764

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G35764

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13-2
(e) Length of stay in Baltimore (yrs., mos., or days) 45 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 801 Pennington ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lena Rice

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F

5. Color or race Wh

6 (a) Single, married, widowed, or divorced. wid.

6 (b) Name of husband or wife Late Joseph S

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years 71 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Meyer Ballan
13. Birthplace Russia

MOTHER
14. Maiden Name Dena
15. Birthplace Russia

16 (a) Informant Matthew Rice
(b) Address 801 pennington ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 1 46 (month) (day) (year)
(c) Cemetery or crematory Mishkan Israel Cem
Location Southern ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1424-26 W. North ave

19 (a) DEC 31 1945 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-31-45 19..., at 4:40 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-30 1945, to 12-31 1945, and that I last saw her alive on 12-31 1945

Immediate cause of death	Duration
Cardiac & Resp. Failure	
Due to Arteriosclerotic & Hypertensive Heart disease	
Due to	
Other Conditions Bronchopneumonia Cerebral accident (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Bertha Rabin M. D.
Address Sinai Hospital Date signed 12/31/45

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

635765

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

9

Registered No. 635765

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Herring Run & Harford Rd.
(c) Hospital or institution: Sydenham Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) 9½ mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1211 Mosher St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Brenda Joyce Hart

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/4/45

8. AGE: Years | Months 4½ | Days 25 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation O

11. Industry or business

FATHER 12. Name William Figrow

13. Birthplace

MOTHER 14. Maiden Name Nellie Hart

15. Birthplace Virginia

16 (a) Informant

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary Cemetery

Location Md.

18 (a) Funeral director Adolphus Hall Est.

(b) Address 918 N. Dennis Hill Ave.

19 DEC 31 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-29 1945 at 5:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-20 1945 to 12-29 1945 and that I last saw h.. alive on 12-29 1945

Immediate cause of death: Pertussis Encephalitis — Duration

Due to: Pertussis

Due to: Pertussis Bronchopneumonia

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Adelphigh Spragins

Address Sydenham Hosp. Date signed 12-30-45

VS 150

G35766

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G35766

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1809 McHenry St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19+
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1809 McHenry St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Amelia M. Thompson

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-10-0985

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: John F. Thompson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 11 1884

8. AGE: Years 61 | Months 3 | Days 18 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Frederick A. Heinecke

13. Birthplace Saxon Germany

MOTHER 14. Maiden Name Anna Felsmann

15. Birthplace Austria

16 (a) Informant Hilda Mae Thompson

(b) Address 1809 McHenry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 31-1945 (month) (day) (year)

(c) Cemetery or crematory Mt Olivet Cem

Location Balto Md

18 (a) Funeral director Paul B. McWalters

(b) Address Pratt & Stricker Sts

19 (a) DEC 31 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 29 1945, at 1a M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1945 to Dec 29 1945, and that I last saw h.. alive on Dec 29 1945.

Immediate cause of death: Pernicious Anemia

Due to

Due to

Other Conditions Chronic Myocarditis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Albert Seagmiller M. D.

Address 1224 W Lombard St Date signed Dec 29 1945

VS 150

635767

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93c

Registered No. 635767

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkins & Caton Aves.
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Howard
(c) City or town Ellicott City R.F.D.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Mayfield (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Artis Wolfe

3 (b) If veteran, name war: None
3 (c) Social Security Account No. 217-22-5429

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: single
6 (b) Name of husband or wife:
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) July 19, 1925

8. AGE: Years 20 | Months 5 | Days 9 | If less than one day: hr. min.

9. Birthplace Maryland (town, county, and state)
10. Usual Occupation Clerk-typist
11. Industry or business Ft Foulke Pub.

FATHER
12. Name Walter Wolfe
13. Birthplace Maryland

MOTHER
14. Maiden Name Emily Phelps
15. Birthplace Maryland

16 (a) Informant Parents
(b) Address Ellicott City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 1, 1946 (month) (day) (year)
(c) Cemetery or crematory St. Johns Cem.
Location Ellicott City, Md.

18 (a) Funeral director Easton Jones
(b) Address Ellicott City, Md.

19 (a) (b) Date received by registrar Huntington Williams, M.D.

DEC 31 1945

VS-150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/24 1945, 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/24 A.M. 1945, to 12/24 P.M. 1945, and that I last saw h[illegible] alive on 12/24 P.M. 1945.

Immediate cause of death: Leukemia — Duration:
Due to: Bilateral Pneumonia
Due to:
Other Conditions: Chronic Rheumatic Cardiac Valve Disease
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:
23. Signature: Cliff Coaitt, Jr.
Address St. Agnes Hosp. Date signed 12/28/45

G35768

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1248 Registered No. G35768

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: South Balto. General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2217 Old Eastern Ave.
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country FINLAND

3 (a) FULL NAME ANNA A. SARLIN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex FEM.

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Frank Sarlin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 20, 1890

8. AGE: Years 55 | Months 8 | Days 8 | If less than one day ____ hr. ____ min.

9. Birthplace Finland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name John Vartiein

13. Birthplace Finland

MOTHER 14. Maiden Name Amanda Vartianen

15. Birthplace Finland

16 (a) Informant Frank A. Sarlin

(b) Address 2217 Old Eastern Ave Rd

17 (a) Cremation (b) Date thereof Jan 1 1946
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location City

18 (a) Funeral director Ulrich Funeral Home

(b) Address 2008 Arlington Av

DEC 31 1945 (b) Huntington Williams, M.D.
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-28 1945 at 5:40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-17 1945 to 12-28 1945, and that I last saw h[illegible] alive on 12-28 1945

Immediate cause of death Cirrhosis of the liver — Duration

Due to

Due to

Other Conditions Hypostatic pneumonia, abdominal adhesions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Joseph S. Ordwiger M. D.

Address 1213 Light St. Date signed 12-28-45

G35769

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

✓ G35769 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 320 E. 27th St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 320 E. 27th (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Schluderberg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife: Amelia W.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 11th 1858

8. AGE: Years	Months	Days	If less than one day
87	2	18	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Butcher

FATHER
12. Name George Schluderberg
13. Birthplace Germany

MOTHER
14. Maiden Name Louise Miller
15. Birthplace Germany

16 (a) Informant Elsie Schluderberg
(b) Address 320 E. 27th st.

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 12/31/45 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Mt. Carmel
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) (b) Huntington Williams M.D. Registrar

DEC 31 1945

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 29 1945, at 11:20 a. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular renal disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Le Gotham M.D. Medical Examiner.
Date signed 12-29-45

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

G35770

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G35770

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 721 N. Luzerne Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 721 South Luzerne Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louisa Davis

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	Widow

6 (b) Name of husband or wife George E. (deceased)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 8, 1860

8. AGE: Years	Months	Days	If less than one day
85	1	21	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation housewife at home
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Henry Hulseman
(b) Address 721 South Luzerne Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/31 45 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel Cemetery.
Location Donell Street

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street

19 (a) (b)
(Date said by registrar) (Registrar)

DEC 31 1945
VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-29 1945, at 1 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 17 1945, to Dec 29 1945, and that I last saw h[illegible] alive on Dec 29 1945.

	Duration
Immediate cause of death Arteriosclerotic & Hypertensive Chronic Myocardial Failure	Jan 1945
Due to Myocardial Failure	12-2-45
Due to	
Other Conditions None	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. Schimunek M. D.
Address 842 Ext Ave Date signed 12-29-45

X

G35771

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G35771

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 333 E. 29th St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 333 E. 29th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary A. Leach

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Charles A. Leach

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 31, 1876

8. AGE: Years 69 | Months | Days 29 | If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Casper H. Timmerman
13. Birthplace Holland

MOTHER
14. Maiden Name Eliza Hughes
15. Birthplace Ireland

16 (a) Informant Mr. Charles A. Leach
(b) Address 333 E. 29th St.

17 (a) Burial (b) Date thereof 1/2/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director H. W. Meamber
(b) Address 805 N. Calvert street

19 (a) DEC 31 1945 (b) Huntington Williams, M.D.
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 30 1945 at 8.00 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1942 19 to 12/30 1945.
and that I last saw h alive on 12/30 19 45.

Immediate cause of death: Acute Coronary Thrombosis — Duration: Sudden

Due to: Arteriosclerosis

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Huntington Williams M.D.

Address 904 Rent Rd Date signed 12/31/45

G35772

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G35772

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Col + Saratoga
(c) Hospital or institution: Mercy
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15d
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2032 E 31st (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Theresa A. Lawton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W.	widow

6 (b) Name of husband or wife George Lawton deceased

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 5 1866

8. AGE: Years	Months	Days	If less than one day
79	11	25	hr. min.

9. Birthplace Maryland. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Jacob Blumph
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs Marie Horton
(b) Address 910 N Ellwood

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/2/46 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North Ave & Rose Sts

18 (a) Funeral director H. W. Meagerson
(b) Address 845 N. Calvert St.

19 (a) [illegible] (Date received by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 30 1945, at 7 15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 29 1945 to Dec 30 1945 and that I last saw her alive on Dec 30 1945

Immediate cause of death Cerebral thrombosis

Due to Cerebral hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration
1 hr.
?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. H. Meyer M. D.
Address Mercy Date signed 2/28/46

VS 150

GB5773

CWK-94715

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

30D

Registered No. GB5773

Please write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5- 8- 22
(e) Length of stay in Baltimore (yrs., mos., or days) 40 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 102 N. Hughes Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Watson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 2-1882

8. AGE: Years	Months	Days	If less than one day
63	9	19	hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Richard Watson (D)
13. Birthplace Virginia

MOTHER
14. Maiden Name Mamie ? (D)
15. Birthplace Virginia

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof 12-31-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Balto City

18 (a) Funeral director Isaiah L. Brown & Son
(b) Address 108 N Montgomery St

19 (a) (b) Huntington Williams, M.D.
(Date received by registrar)

DEC 31 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH December 21 1945, at 1:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 13 1945, to Dec. 21 1945, and that I last saw h im alive on Dec. 21 1945

Immediate cause of death: aneurysm of abdominal aorta — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature T. P. Jerrigan M. D.
Address Baltimore City Hall Date signed 12-26-45

X

G35774

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. G35774

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Caroline & Oliver Sts.
(c) Hospital or institution: St. Josephs
(d) Length of stay in hospital or inst. (yrs., mos., or days): 2 days
(e) Length of stay in Baltimore (yrs., mos., or days): Life

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County: ***
(c) City or town: Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 3442 Cliftmont Ave. (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME: Irene F. Hamel

3 (b) If veteran, name war	3 (c) Social Security Account No.
***	*****

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Wht.	Single

6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 13, 1935

8. AGE: Years	Months	Days	If less than one day
10	--	16	..... hr. ..... min.

9. Birthplace: Balto. Md. (Town, county, and state)
10. Usual Occupation: School Girl
11. Industry or business

FATHER
12. Name: Erwin F. Hamel
13. Birthplace: Balto. Md.

MOTHER
14. Maiden Name: Wilda F. Adams
15. Birthplace: Balto. Md.

16 (a) Informant: Erwin F. Hamel
(b) Address: 3442 Cliftmont Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Jan. 2, 1946 (month) (day) (year)
(c) Cemetery or crematory: Oak Lawn
Location: Eastern Ave. Balto. Co.

18 (a) Funeral director: Robert S. Little
(b) Address: 2700 Edmondson Ave.

DEC 31 1945 (Registrar) Huntingtown, Williamsport Md.

MEDICAL CERTIFICATION

28. DATE OF DEATH: 12/29 19 45 at 10:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/27 19 45 to 12/29 19 45
and that I last saw h[illegible] alive on 12/29/19 45

Immediate cause of death: Respiratory Failure — Duration
Due to: during Anesthesia
Due to: Shock
Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation: 12/29/45
Major findings of operation: Ununited left femur
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 26/3
(a) Accident, suicide, ~~Homicide~~? Accident
(b) Date of occurrence: ~~Dec. 29, 1945~~ at 9 AM
(c) Where did injury occur? In front of above address (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Public (Specify type of place) While at work? no
(e) Means of injury: Thrown to ground while
23. Signature: [illegible]
Address: [illegible] Date signed: 12/29/45

VS 150

(OVER) Howard J. Rinehart, M.D. 475

GB5775

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. GB5775

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1823 E. Balto St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give name)
(d) Street No. 1823 E Balto St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Ziff

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife Isadore

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1890

8. AGE: Years 55 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation House Work.

11. Industry or business

FATHER
12. Name Sam Carp
13. Birthplace Russia

MOTHER
14. Maiden Name Dora
15. Birthplace Russia

16 (a) Informant Husband.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-31-45 (month) (day) (year)
(c) Cemetery or crematory Bnai Israel
Location Southern Ave

18 (a) Funeral director Jack Levy Inc
(b) Address 1439 E. Balto St

DEC 31 1945 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 30 Dec 1945, at 4.00 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry (Autopsy, Inspection or Inquiry), find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William L. Hellrich M.D. Medical Examiner
Date signed 31 Dec 45

635776

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

635776 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Mercy Hosp
(c) Hospital or institution: Cath. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 6 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5 S. Bethesda St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Samuel J. Cascio

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W.

6 (b) Name of husband or wife Louise Cascio

6 (c) If alive, give age deceased years

7. Birth date of deceased (mo., day, yr.) July 12, 1891

8. AGE: Years	Months	Days	If less than one day
54	5	18	hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Shoeper

11. Industry or business

FATHER 12. Name Phillip Cascio

13. Birthplace Italy

MOTHER 14. Maiden Name Louise ?

15. Birthplace Italy

16 (a) Informant Phillip Cascio

(b) Address 3110 East Baltimore St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 2-46 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Belair Road

18 (a) Funeral director Frank W. Ridgestone

(b) Address 2815 E. Baltimore St.

DEC 31 1945 (Date received by local registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 30 1945, at 4 50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 27 1945 to Dec 30 1945 and that I last saw h/ her alive on Dec 30 1945

Immediate cause of death Coronary Occlusion — Duration 6 days

Due to Coronary thrombosis — 17 days

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Paul R. Meyers

Address Mercy Hosp Date signed 12/31/45 M. D.

X

G35777

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

Registered No. G35777

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 701 Mosher St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 701 Mosher St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Milton Scott

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	colored	married

6 (b) Name of husband or wife Lillie Scott
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 30, 1905

8. AGE: Years	Months	Days	If less than one day
40	4	29	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Presser
11. Industry or business

FATHER
12. Name Fred Scott
13. Birthplace Md

MOTHER
14. Maiden Name Hannah Jolley
15. Birthplace Md

16 (a) Informant Lillie Scott
(b) Address 701 Mosher St

17 (a) Burial (b) Date thereof 12-31-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus
Location Md

18 (a) Funeral director George G. Nelson
(b) Address 1303 Presstman St

(a) [illegible] (b) Huntington Williams M.D.

DEC 31 1945

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 28 1945, at 10 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1942 to Dec 28 1945, and that I last saw him alive on Dec 27 1945.

Immediate cause of death Pulmonary Tuberculosis — Duration 3 yrs

Due to

Due to

Other Conditions Hypostatic

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: none

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Ralph H Young M. D.
Address 1424 E Monument St Date signed Dec 29 1945

correct age is especially important. Physicians: please write the causes of death clearly and legibly

G35778 BALTIMORE CITY HEALTH DEPARTMENT G35778

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
Us Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 days
(e) Length of stay in Baltimore (yrs., mos., or days) 23 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Annapolis
(If outside city or town limits, write RURAL and give town)
(d) Street No. 24 Annapolis Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Sites, John Edward

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-03-4799

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Evelyn Sites

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Nov. 12, 1906

8. AGE: Years 39 | Months 1 | Days 18 | If less than one day ..... hr. ..... min.

9. Birthplace Balto, Md.
(Town, county, and state)

10. Usual Occupation Stock room clerk

11. Industry or business Merchant Marine

FATHER
12. Name Edward F. Sites
13. Birthplace Balto, Md.

MOTHER
14. Maiden Name Rosalie Gouker
15. Birthplace Balto, Md.

16 (a) Informant Records
(b) Address US Marine Hospital, Balto, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 3-46 (month) (day) (year)
(c) Cemetery or crematory Cedar Bluff Cem.
Location Annapolis Md.

18 (a) Funeral director E W Lamoreau
(b) Address 4510 Liberty Heights Ave

19 (a) (Date received by local registrar) Huntington Williams M.D.

DEC 31 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 30 1945, at 9:35A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 7 1945 to Dec. 30 1945, and that I last saw h im alive on Dec. 30 1945.

Immediate cause of death Pneumonia, bronchial, both lower lobes, terminal — Duration Several Days

Due to Carcinoma right lung with metastasis to spinal cord — Duration UNKNOWN

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? .....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature John L. Wilson
John L. Wilson, Sr. Surgeon
Address Clinical Director Date signed 12/31/45

correct age is especially important. Physicians: please write the

GB5779

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V131a

Registered No. GB5779

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1261 Washington Blvd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1261 Washington Blvd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nannie F. Eichler (Sheffler)

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Wm A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 6, 1872

8. AGE: Years	Months	Days	If less than one day
73	2	24	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name Barton
13. Birthplace Virginia

MOTHER
14. Maiden Name
15. Birthplace Unknown

16 (a) Informant Mrs Mary M. Jones
(b) Address 424 E. 30th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof January 2, 1946 (month) (day) (year)
(c) Cemetery or crematory Edenburg Cem.
Location Edenburg Va.

18 (a) Funeral director John F. Denny Inc
(b) Address 714 Eight St.

19 DEC 31 1945 (Date rec'd by registrar) Herrington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/30 1945 at 10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/20/45 19 to 12/30 1945
and that I last saw h alive on 12/20 1945.

Immediate cause of death	Duration
Acute Cardiac Failure	1 da
Due to Cardiovascular Renal Disease	6 mos
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph L. Lansdale M. D.
Address 1261 Washington Blvd Date signed 12/31/45

VS 150

G35780

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G35780 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2004 Homewood Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2004 Homewood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CARRIE HAUGHEY

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: John B. Haughey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 2, 1862

8. AGE: Years 83 | Months 2 | Days 27 | If less than one day hr. min.

9. Birthplace Alexandria, Va. (Town, county, and state)
10. Usual Occupation at Home
11. Industry or business

FATHER
12. Name McKewin
13. Birthplace Va.

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mr. Robert A. Haughey
(b) Address 636 McKewin Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/31/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (b) (Signature of local registrar)

DEC 31 1945

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 29, 1945, at 8:15A.M

21. I certify that death occurred on the date above stated; that I attended deceased from February 1945, to December 1945, and that I last saw h. or alive on Dec 28th 1945

Immediate cause of death Pulmonary edema — Duration 2 days

Due to Acute Bronchitis — 2 weeks

Due to Chronic Myocarditis — ?

Other Conditions Senility

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. B. Haughey M.D.
Address 1901 Eutaw Place, City Date signed 12/29/45

Please write the causes of death clearly and legibly. Physicians: please write age is especially important.

G35781

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. G35781

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1615 E. 25th St.
(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1615 E. 25th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EDWARD B. HUFFMAN

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Julia A. Huffman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 8, 1867

8. AGE: Years 78 | Months 4 | Days 9 19 | If less than one day hr. min.

9. Birthplace Morgan Co., W. Va.
(Town, county, and state)

10. Usual Occupation Retired Conductor

11. Industry or business B. & O. R. R.

FATHER
12. Name Arthur Huffman
13. Birthplace W. Va.

MOTHER
14. Maiden Name Herrah V. Lowman
15. Birthplace Unknown

16 (a) Informant Mrs. Lillian Eichelberger
(b) Address 733 Brookwood Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/31/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) DEC 31 1945 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH Dec. 27, 1945, at 11:57 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1942 to Dec. 27 1945, and that I last saw alive on Dec. 24 1945.

Immediate cause of death	Duration
Cerebral Hemorrhage	(unk)
Due to Hypertension and arteriosclerotic C-V disease	4 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. H. Eichelberger M. D.

Address 1428 Ringgold Date signed 12-29-45

correct age is especially important. Physicians: please write the

G35782

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G35782

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2651 Maryland Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2651 Maryland Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ALBERT W. MEEKS

3 (b) If veteran, name war: none
3 (c) Social Security Account No. 212-01-8333

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Emma L. Meeks
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 27, 1878

8. AGE: Years 67 | Months 7 | Days 1 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Foreman-Packing Dept.
11. Industry or business Carr Lowry Glass Co.

FATHER
12. Name William Meeks
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Rebecca Wilson
15. Birthplace Md.

16 (a) Informant Mr. W. Harlan Meeks
(b) Address 2448 Pickwick Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/31/45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 DEC 31 1945 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/28/45 19..., at 8:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/22 1945, to Dec 1945, and that I last saw h.m alive on 1945.

Immediate cause of death: Coronary Thrombosis — Duration 4 mnths.
Due to: Arteriosclerosis - Generalized — 2 yrs
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M. D.
Address 301 Cumberland Date signed 12/30/45

VS 150

635783

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 513

Registered No. 635783

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered and answered as correctly as possible. Be sure to write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3927 Cloverhill Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3927 Cloverhill Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Bright Kelly

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Pattie Tenney Kelly
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 16, 1881

8. AGE: Years	Months	Days	If less than one day
64	10	13	hr. min.

9. Birthplace Queen Anne Co., Md. (Town, county, and state)
10. Usual Occupation Commercial Traveler
11. Industry or business

FATHER
12. Name Richard Kelly
13. Birthplace Ireland

MOTHER
14. Maiden Name Laura Bright
15. Birthplace Md.

16 (a) Informant Mrs. Patricia L. Kelly
(b) Address 3927 Cloverhill Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/31/45 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
Address Balto., Md.

19 (a) DEC 31 1945 (Date rec'd by registrar) (b) Huntington Williams REGISTRAR

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 29, 1945, at 11½ a M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 28 1945 to Dec 29 1945, and that I last saw him alive on Dec. 29 1945

Immediate cause of death	Duration
Carcinoma of prostate with metastasis to medias-	3 years
Due to Chronic Cystitis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation February 1942
Major findings of operation: Carcinoma of prostate
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. W. Hoffman M. D. M. D.
Address 8 East Read St. Date signed 12/31/45

VS 150

G35784 G35784

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green
(c) Hospital or institution: Univ. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2212 Garrison Blvd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Erna M. Engelhardt

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	widowed

6 (b) Name of husband or wife Dr. Herman Engelhardt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 1, 1863

8. AGE: Years	Months	Days	If less than one day
82	10	29	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name George Schweckendick
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Lange
15. Birthplace Germany

16 (a) Informant Mrs. Minnette E. Scott
(b) Address 2500 Queen Ann Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/2/46 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 DEC 31 1945 (b) Huntington Williams, M.D. Registrar
(Date received by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-30 1945 at 11 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-27 1945 to 12-30 1945 and that I last saw her alive on 12-30 1945

Immediate cause of death	Duration
Myocardial failure	
Due to Auricular fibrillation	
Due to Arteriosclerotic Cardiovascular disease	
Other Conditions General Thrombosis Mesenteric Thrombosis Ruptured ulcer	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. L. Butler M. D.
Address Univ. Hosp. Date signed 12-30-45

G35785

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G35785

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2507 Chelsea Terr.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2507 Chelsea Terrace
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY ELIZABETH DARBY

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Taylor Darby
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 19, 1858

8. AGE: Years	Months	Days	If less than one day
87	8	10	hr. min.

9. Birthplace Martinsburg, W. Va.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Darius Darby
13. Birthplace Martinsburg, W. Va.

MOTHER
14. Maiden Name Catherine Mantz
15. Birthplace Martinsburg, W. Va.

16 (a) Informant Mrs. F. J. Orban
(b) Address 2507 Chelsea Terr.

17 (a) Burial (b) Date thereof 12/29/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Maryland

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 DEC 31 1945 (b) Huntington Williams, M.D.
(Date rec'd by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 29, 1945, at 11:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 26 1945 to Dec 28 1945 and that I last saw her alive on Dec 28 1945

Immediate cause of death	Duration
Cerebral hemorrhage + paralysis	3 days
Due to	
Due to Adrenal uterus salpingo oophorectomy	about 5 yrs.
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hallie E. Dutcher M. D.
Address 2220 Harrison Blvd Date signed Dec 30/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35786

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92a

G35786 Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ~~Robert Gibbon~~ Lombard & Greene Sts
(c) Hospital or institution: University Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2310 Callow Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME WILLIAM LAY BOURNE

3 (b) If veteran, name war: NONE

3 (c) Social Security Account No. 265-03-1780

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: —

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Feb. 23, 1913

8. AGE: Years 32 | Months 10 | Days 6 | If less than one day ____ hr. ____ min.

9. Birthplace Rochester, N. Y. (Town, county, and state)

10. Usual Occupation Cook

11. Industry or business Super-Diner

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Sarah Watkins
15. Birthplace Canada

16 (a) Informant Miss Estelle Nolan
(b) Address 2128 Brookfield Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/31/45 (month) (day) (year)
(c) Cemetery or crematory St. Peters Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) DEC 31 1945 (Date rec'd by registrar) (b) Huntington Williams, M. D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-29 1945 at 2.50 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-25 1945 to 12-29 1945, and that I last saw him alive on 12-29 1945.

Immediate cause of death Cardiac Failure — Duration: ____

Due to Rheumatic C.V.Dis 2 — Duration: 7 days

Active Rheumatic Fever — Duration: 15 days

Due to (Mitral & Aortic Stenosis) — Duration: 4 15 days

Other Conditions Pneumonia Left Base

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: none

of autopsy: Not permitted

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide None
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Eugene N. Cornuz M.D. M. D.

Address Univ. Hosp. Date signed 12-29

635787

635787

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution: Maryland General 15-11
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3710 Egerton Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John G. Herman

3 (b) If veteran, name war: None

3 (c) Social Security Account No. None

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ella May Herman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1, 1869

8. AGE: Years 76 | Months 9 | Days 28 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Insurance Adjuster

11. Industry or business Self

FATHER
12. Name Henry W. Herman
13. Birthplace Germany

MOTHER
14. Maiden Name Rosa Oehr
15. Birthplace Balto., Md.

16 (a) Informant Miss Rosella Herman
(b) Address 3710 Egerton Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/31/45 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WILLIAM J. TICKNER & SONS.
(b) Address Balto., Md.

19 (a) DEC 31 1945 (Burial or cremation) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/29 1945; at 9:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/28 1945 to 12/29 1945; and that I last saw him alive on 12/29 1945.

	Duration
Immediate cause of death: Coronary Thrombosis	24 hrs.
Due to: Arteriosclerotic CV. Disease	
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Martin E. Strobel M. D.
Address Md. Gen'l. Hospital Date signed 12/29/45

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly

G35788

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1939

G35788 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 518 South Broadway
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town 518 S. Broadway (If outside city or town limits, write RURAL and give town)
(d) Street No. 518 S. Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Green

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Maried

6 (b) Name of husband or wife: Jennie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) aug 10-1890

8. AGE: Years	Months	Days	If less than one day
55	4	19	hr. min.

9. Birthplace Detroit Michigan (Town, county, and state)
10. Usual Occupation Fireman
11. Industry or business Curtis Bay Towing Co.

FATHER
12. Name Walter Green
13. Birthplace Colorado

MOTHER
14. Maiden Name Serra Hoffman
15. Birthplace Canada

16 (a) Informant Jennie Green
(b) Address 518 S. Broadway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 31-45 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave

18 (a) Funeral director Wm. S. Fialkowski
(b) Address 2007 Eastern Ave

DEC 31 1945 (a) (Date rec'd by registrar) (b) Registrar

VS 151

Hunting for Williams, M.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/29/45 19..., at 6:30 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes X, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Davis M.D.
Medical Examiner.
Date signed 12/30/45

635789

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1147 D

Registered No. 635789

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto. Gen. Hosp. 2
(d) Length of stay in hospital or institution (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No 1630 Benhill Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Dembowski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Mary Dembowski

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? 1882

8. AGE: Years 63 | Months | Days | If less than one day ___ hr. ___ min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Mary Dembowski
(b) Address 1630 Benhill Ave

17 (a) Burial (b) Date thereof 1-2-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location A. A. Cath.

18 (a) Funeral director Wm. L. Fialkowski
(b) Address 2007 Eastern ave

19 (a) 1-1-1945 (b)
(Date received by registrar) Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 29 1945, at 4:23 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 13 1945 to Dec 29 1945 and that I last saw h/M alive on Dec 29 1945

Immediate cause of death Lung Abscess — Duration ?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leo. E. Wheeler M. D.

Address Gold Balto Gen. Date 12/29/45

X

Certify age is especially important. Physicians: please write the causes of death clearly and legibly

G35790

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G35790
Registered No.

Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green Sts.
(c) Hospital or institution: Univ. Hosp. 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. 9
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3434 Erdman Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary A Greenwood

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife AUTHER

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY 22 - 1858

8. AGE: Years	Months	Days	If less than one day
57	7	6	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name John Naumann
13. Birthplace Germany

MOTHER
14. Maiden Name Wroten
15. Birthplace Virginia

16 (a) Informant Mrs. Emma Wroten
(b) Address 4 Clinton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/31/45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Mem
Location Taylor ave

18 (a) Funeral director Clarence F. Hoffman
(b) Address 1639 N Broadway

19 DEC 31 1945 (Date rec'd by registrar) Huntington, Indiana

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 28. 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-29 1945 to 12-28 1945 and that I last saw h[illegible] alive on 12-28 1945

Immediate cause of death: Myocardial failure
Due to: Lobar pneumonia
Due to:
Other Conditions:

Duration

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles J. Bullen M. D.
Address Univ. Hosp. Date signed 12-29-45

635791

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 477

635791 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Sandiman
(c) Hospital or institution:
Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 -
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 736 E Pleasant ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Edward Lenty

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife Esther Winterberg

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 5 - 1885

8. AGE: Years	Months	Days	If less than one day
60	-	25	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Longshoreman
11. Industry or business

FATHER
12. Name Henry Lenty
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Augusta Martin
15. Birthplace Baltimore Md

16 (a) Informant Henry L Lenty
(b) Address Balto Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/3/46 (month) (day) (year)
(c) Cemetery or crematory Meadow Ridge
Location Walbrook Balto

18 (a) Funeral director Clarence F Hoffman
(b) Address 1639 N Broadway

DEC 31 1945 (b)
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 30 1945, at 7 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 21 1945 to Dec 30 1945, and that I last saw h[illegible] alive on Dec 30 1945.

Immediate cause of death
Carcinoma of lung
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. M. Cousiel M. D.
Address Maryland Gen Hosp Date signed 12-30-45

correct age is especially important. Physicians: please write the causes of death clearly and legibly

G35792

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. G35792

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 410 S. Collington Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 410 S. Collington Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MARTHA FIGINSKI

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Anthony
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 18, 1868

8. AGE: Years	Months	Days	If less than one day
77	11	12	hr. min.

9. Birthplace Trzemeszno, Poland
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Anthony Nowicki
13. Birthplace Poland

MOTHER
14. Maiden Name Anna Kranz
15. Birthplace Poland

16 (a) Informant Miss Helen A. Figinski
(b) Address 410 S. Collington Avenue

17 (a) Burial (b) Date thereof 1/2/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Mt. Carmel Road

18 (a) Funeral director M. F. Sadowski & Sons
(b) Address 1808 Eastern Ave. Baltimore, Md.

19 DEC 31 1945 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 30, 1945, at 11:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 22 1945, to Dec. 30 1945, and that I last saw her alive on Dec. 30 1945.

	Duration
Immediate cause of death Coronary Occlusion	12/30/45
Due to Arteriosclerotic Hypertensive Cardio-Vascular Dis.	??
Due to	
Other Conditions Lobar Pneumonia	12/22/45 - 12/28/45

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph E. Drenga, M.D.
Address 209 W. Chesterfield Date signed 12/31/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly

VS 150

937

G35793

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G35793 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greenspring & Belvedere Aves
(c) Hospital or institution:
Levindale Hebrew Home & Infirm.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3824 Donner Road (if rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Abraham J Sugar

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Kate

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1858

8. AGE: Years 87 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace: Russia (Town, county, and state)

10. Usual Occupation: retired

11. Industry or business

FATHER
12. Name: Eliza ?
13. Birthplace: Russia

MOTHER
14. Maiden Name: unknown
15. Birthplace: Russia

16 (a) Informant: Benj Sugar
(b) Address: 1628 N Appleton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-1-46 (month) (day) (year)
(c) Cemetery or crematory: Rosedale
Location: Hamilton & Thula Road

18 (a) Funeral director: Jack Lewis Inc
(b) Address: 1709 E Balto St

19 (a) (Date received by local registrar) (b) Hunting Williams, M.D. Registrar

DEC 31 1945

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 30 1945, at 5 45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 26 1945 to Dec 30 1945 and that I last saw h[illegible] alive on Dec. 30 1945.

Immediate cause of death: Cerebral arteriosclerosis — Duration
Due to: Hypertension
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: H Edmund L Kern M. D.
Address: Levindale Date signed: Dec 31 1945

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

635794

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No. 635794

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 814 N. Calhoun St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 814 N. Calhoun St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph S. Anderson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Col	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1869

8. AGE: Years	Months	Days	If less than one day
76			hr. min.

9. Birthplace Hanover Co. [redacted] Va. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Charles Anderson
13. Birthplace Va

MOTHER
14. Maiden Name Mary Coleman
15. Birthplace Va

16 (a) Informant Virginia Anderson
(b) Address 814 N. Calhoun St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/31/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantley ave

19 (a) DEC 31 1945 (Date received by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-25-45 1945, at 5:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/15 1945, to 12-25 1945, and that I last saw h[illegible] alive on 12-25 1945.

Immediate cause of death Cerebral thrombosis

Due to Hypertension and C.V. disease

Due to Renal Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [redacted] M. D.
Address 805 N. Fremont

correct age is especially important. Physicians: please write the causes of death clearly and

G35795 | BALTIMORE CITY HEALTH DEPARTMENT | G35795

CERTIFICATE OF DEATH 1945

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give name)
(d) Street No. 2005 St Clair Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Minacapelli

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	—

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 26, 1944

8. AGE: Years	Months	Days	If less than one day
1	14	3	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name Phillip Joseph Minacapelli
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Josephine Juliano
15. Birthplace Baltimore Md.

16 (a) Informant Mr. Phillip J. Minacapelli
(b) Address 2005 St Clair Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 2, 1945 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4430 Belair Rd.

18 (a) Funeral director Edgar W. Gorsuch & Son
(b) Address 924 E. Eager St.

19 DEC 31 1945 (c) Hunting for Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-29- 1945, at 2 45 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation

Due to Aspiration of Orange seed

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-29-45 2:40 P. M. 8/5
(b) Where did injury occur? 2005 St Clair Lane
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no
(d) Means of injury Aspiration of orange seed

23. Signature Benedict Skotarelic M.D.
Medical Examiner.
Date signed 12-30-45

635796

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √10

Registered No. 635796

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Herring Run & Harford Rd.
(c) Hospital or institution Lyndenham Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1013 Stricker St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Bernard Randolf Hoover (Stepney)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 7, 1941

8. AGE: Years 4 5 | Months 11 | Days 18 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Marion Hoover
13. Birthplace Atlantic City, N.J.

MOTHER
14. Maiden Name Ruth Stephney
15. Birthplace Baltimore, Md.

16 (a) Informant Ruth Stephney
(b) Address 606 N. Carey St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 30 '45 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Wilkins
(b) Address 332 N. Schroeder St.

19 DEC 31 1945 (b) Huntington Williams, M.D.
(Date received by local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 25 1945, at 3 15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-23 1945 to 12-25 1945 and that I last saw h. alive on 12-25 1945.

Immediate cause of death	Duration
Diphtheritic Myocarditis	
Due to Diphtheria,	
Due to Pharyngeal	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Melchijah Sprague M.D.
Address Lyndenham Hosp. Date signed 12-26-45

VS 150

write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

G35797

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945D

Registered No. G35797

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ. Hospital 18-2

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 786 Booth St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julia Jackson Samuel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widow

6 (b) Name of husband or wife Robert

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1842

8. AGE: Years	Months	Days	If less than one day
63			hr. min.

9. Birthplace Essex Co. Va.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name William Jones
13. Birthplace Essex Co. Virginia

MOTHER
14. Maiden Name Amanda
15. Birthplace Essex Co. Virginia

16 (a) Informant Ruth Johnson
(b) Address 205 W. Chamberlain St

17 (a) Burial (b) Date thereof Jan. 2-46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Edmondson St.

19 (a) DEC 31 1945 (b) Huntington Williams, Jr.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 27 Dec 1945, at 11:30 M

21. I certify that I took charge of the remains described above, held an Inquest thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute pulmonary Edema

Due to Chronic Myocardial degeneration

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J. Helpern M.D. Medical Examiner.
Date signed 28 Dec 45

VS 151

G35798

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. G35798

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1413 W Saratoga St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1413 W Saratoga St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Thomas White

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Emily White
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace North Carolina
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Emory White
13. Birthplace N.C.

MOTHER
14. Maiden Name Emma —
15. Birthplace N.C.

16 (a) Informant Richard White
(b) Address 1413 W Saratoga St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 31-1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 32 N. Schroeder St.

DEC 31 1945
(Date rec'd by registrar) Huntington Williams Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH December 25 1945 at 9:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1943 to 12/25 1945
and that I last saw him alive on 11/15 1945

Immediate cause of death	Duration
Coronary Thrombosis	
Due to Hypertensive Heart-Disease	
Due to Generalized Arterio-sclerosis	
Other Conditions Hypertrophy of Prostate	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. Wallis Sherwood M. D.
Address 201 N Carey Date signed 12/31/45

G35799 AB- 97964

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

G35799 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8days
(e) Length of stay in Baltimore (yrs., mos., or days) 55yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimor
(If outside city or town limits, write RURAL and give town)
(d) Street No. 612 Main St-Turners Station
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ernest White

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Helen

6 (c) If klive, give age years

7. Birth date of deceased (mo., day, yr.) July 9- 1890

8. AGE: Years 55 | Months 5 | Days 19 | If less than one day ...hr. ...min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Sam White
13. Birthplace Va.

MOTHER
14. Maiden Name Katie ?
15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals(Record
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof 12/31/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location

18 (a) Funeral director Adolph Katz
(b) Address 4 S. Bond St.

(c) (Signature of funeral director) (Signature of Registrar)

DEC 31 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 28- 1945, at 1.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-20 1945, to 12-28- 1945, and that I last saw him alive on 12-28 1945.

Immediate cause of death: Pulmonary tbc.
Due to Bronchopneumonia
Due to Carcinoma
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
Date of autopsy: Carcinoma, Bronchopneumonia, tuberculosis, C.A. prostate

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Margaret Van Sant
Address B-E'H. Date signed 12/31/45 M. D.

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

635800 BALTIMORE CITY HEALTH DEPARTMENT 635800

CERTIFICATE OF DEATH V 33a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Hosp
Sanitarium Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days) 25

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 408 Seagull Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Craig

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color: ~~Colored~~

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ruth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 4 1918

8. AGE: Years 27 | Months 8 | Days 24 | If less than one day hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation Welder

11. Industry or business Bethlehem Ship Yard

FATHER
12. Name William Craig
13. Birthplace Va.

MOTHER
14. Maiden Name Jennie Fowlkes
15. Birthplace Va.

16 (a) Informant Bernard Fowlkes
(b) Address 102 S McDonough St

17 (a) Removal (b) Date thereof Dec 31/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Victoria Virginia

18 (a) Funeral director Mrs. Robert G. Elliott
(b) Address 1129 N. Caroline St

19 DEC 31 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 28 1945, at 8:50 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Pneu death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Lobar Pneumonia, Bilateral

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard A. Clendenin M.D.
Medical Examiner.
Date signed 12-29-45

VS 151

(over)

accident room
635801

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH √83a

635801 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1227 E. Biddle St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dora Mitchell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	Black	Widow

6 (b) Name of husband or wife Winslow

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 15 1883

8. AGE: Years	Months	Days	If less than one day
60	4	14	hr. min.

9. Birthplace N. C.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Jim Fuller
13. Birthplace N. C.

MOTHER
14. Maiden Name Charity Boone
15. Birthplace N. C.

16 (a) Informant Ella Spivey
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (b) Date thereof Dec 31/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Durham N. C.

18 (a) Funeral director Mrs. Robert A. Elliott & Sons
(b) Address 1129 N. Caroline St

19 (a) DEC 31 1945 (b)
(Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-29 1945 at 9 A M

21. I certify that death occurred on the date above stated; that I attended deceased from DEC 29 1945 to DEC 29 1945 and that I last saw h CR alive on DEC 29 1945

Immediate cause of death	Duration
CEREBRAL HEMORRHAGE, →	20 MINS.
MASSIVE	
Due to	
HYPERTENSION →	8 YRS.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: AS ABOVE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. P. Draper, Jr. M.D.
M. D.
Address Johns Hopkins Hospital Date signed Dec 29, 1945

G35802

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G35802

Please write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 927 Forest St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Bessie Walker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-27-27.

8. AGE: Years	Months	Days	If less than one day
18	5	1	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Archie Walker.
13. Birthplace Md.

MOTHER 14. Maiden Name Hattie Bass
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 1, 1946 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem.
Location A A County Md

18 (a) Funeral director Mrs. Robert A. Elliott & Bro
(b) Address 1129 N. Caroline St

19 (a) 31 1945 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 28 1945 at 9.10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 28 1945 to Dec. 28 1945 and that I last saw h.r alive on Dec. 28 1945.

Immediate cause of death Myocarditis Grade 4 with Hypertensive Cardiac — Duration 2 years

Due to

Due to

Other Conditions Chronic nephritis, etiology undetermined (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature David Hoff M. D.
Address Johns Hopkins Hospital Date signed Dec 28 '45

Certificate from Baltimore, Md.

X

G35803

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93

G35803 Registered No.

1. PLACE OF DEATH: DOA
(a) Baltimore City, Maryland
(b) Street address 806 Shuter St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 806 Shuter St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie Rowland

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widow

6 (b) Name of husband or wife Charles

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 2, 1875

8. AGE: Years	Months	Days	If less than one day
70	8	27	hr. min.

9. Birthplace Essex County Va.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Lewis Ballard
13. Birthplace Va.

MOTHER
14. Maiden Name Lucy Johnson
15. Birthplace Va.

16 (a) Informant Harry W Rowland
(b) Address 816 Shutter St

17 (a) Burial (b) Date thereof Dec 31/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A.A County Md.

18 (a) Funeral director Mrs Robert A. Elliott
(b) Address 1129 N. Caroline St.

19 (a) DEC 31 1945 (b) [illegible]
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/28 1945, 3:35 P M

21. I certify that I took charge of the remains described above, held an Autopsy-Inquest thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature P. J. Sobieski M.D.
Medical Examiner.
Date signed 12/29/45

VS 151

G35804

BALTIMORE CITY HEALTH DEPARTMENT BUNN

CERTIFICATE OF DEATH 830

G35804 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2831 Frederick Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) 65 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2831 Frederick Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Henry Bunn

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Katherine E Bunn

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 14 1880

8. AGE: Years 65 | Months 5 | Days 15 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Butcher

11. Industry or business Lexington Market

FATHER
12. Name Peter J. Bunn
13. Birthplace Bavaria Germany

MOTHER
14. Maiden Name Agnes Shaak
15. Birthplace Baltimore Md

16 (a) Informant Katherine E Bunn
(b) Address 2831 Frederick Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 2 1946 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore Md

18 (a) Funeral director Harry N Ammerman
(b) Address 4201 Pedgewood Ave

(c) Date received DEC 31 1945 (Registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 29 1945 at 5.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1943 to Dec 29 1945 and that I last saw him alive on Dec 29 1945

Immediate cause of death: Cerebral Hemorrhage — Duration 6 hrs

Due to: General Arterio Sclerosis — 3 years

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Eliot W Johnson M. D.
Address 3432 Sudbrook Date signed

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

635805

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. 635805

Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2821 Christopher Ave
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2821 Christopher Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country —

3 (a) FULL NAME LETITIA VIRGINIA GILL

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Charles McLean Gill
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) December 18, 186[illegible]

8. AGE: Years	Months	Days	If less than one day
82	0	13	— hr. — min.

9. Birthplace Yeoho, Baltimore County (Town, county, and state)
10. Usual Occupation None
11. Industry or business —

FATHER
12. Name William Akehurst
13. Birthplace England.

MOTHER
14. Maiden Name Ann Hook
15. Birthplace Maryland

16 (a) Informant Mrs. Ruth Deck
(b) Address 2821 Christopher Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-2-46 (month) (day) (year)
(c) Cemetery or crematory Black Rock
Location

18 (a) Funeral director Leonard J. Rucker
(b) Address 1805 Harford Road

19 (a) DEC 31 1945 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 31 1945 at [illegible] M

21. I certify that death occurred on the date above stated; that I attended deceased from — 1937 to Dec 31 1945 and that I last saw her alive on Dec 26 1945

Immediate cause of death: Bronchopneumonia — Duration 7 days
Due to: Senility — 12 yrs
Due to: —
Other Conditions: —

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operations —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. S. Chestnut M. D.
Address 6210 York Rd Date signed Dec 31, 45

635805 Wehner 635805

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline & Oliver Sts.
(c) Hospital or institution:
St. Joseph's Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 401 N. Streeper St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Gertrude Wehner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married.

6 (b) Name of husband or wife John J. Wehner

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1 | 14 | 69

8. AGE: Years 76 | Months 11 | Days 16 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name Besel
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mrs John J Wehner
(b) Address 401 N. Streeper St.

17 (a) Burial (b) Date thereof 1-2-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto

18 (a) Funeral director Leopard J. Ruck
(b) Address 5905 Harford Rd.

19 (a) 1-1-1945 (b) Martin J. Williams Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 | 30 1945 at 4:35 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/21 1945 to 12/30 1945 and that I last saw h[illegible] alive on 12/30 1945.

Immediate cause of death Cardiac - Respiratory Failure — Duration

Due to Cerebral Hemorrhage

Due to

Other Conditions Left-sided Hemiplegia
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. T. Everett M. D.

Address St. Joseph's Hosp. Date signed 12/30/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly

VS 150

635807

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. 635807

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 904 Ramsay St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21-
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 904 Ramsay St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hester E. Murphy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex female | 5. Color or race white | 6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 15th 1879

8. AGE: Years 66 | Months 4 | Days 17 | If less than one day hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation housework

11. Industry or business at home

FATHER
12. Name Cornelius Murphy
13. Birthplace Ireland

MOTHER
14. Maiden Name Ellen Connell
15. Birthplace Ireland

16 (a) Informant Mrs F. Roland Murphy
(b) Address 904 Ramsay St

17 (a) burial (b) Date thereof 1/2/46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Rd

18 (a) Funeral director John J Gowan Son
(b) Address 901 Hollins St

19 DEC 31 1945 (b) Huntington Williams, M.D.
(Date received by local registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 30th 1945, at 6:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 29 1945 to Dec 30 1945, and that I last saw here alive on Dec 29 1945.

Immediate cause of death	Duration
Cerebral Hemorrhage, right	12 hrs.
Due to Hypertensive Cardiov. Vascular Renal Disease	6 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John P. Ulrich Jr M. D.
Address 1227 Wash Blvd Date signed 12-31-45

G35808 | BALTIMORE CITY HEALTH DEPARTMENT | G35805

CERTIFICATE OF DEATH

164 C | Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 2 hours
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State: Maryland (b) County
(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No.: 1141 Ellicott Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Lindsay Parks

3 (b) If veteran, name war: NONE
3 (c) Social Security Account No.: 225-10-3293

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Maude H. Parks
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): April 19, 1905

8. AGE: Years	Months	Days	If less than one day
40	8	16	hr. min.

9. Birthplace: Greensboro, N. C. (Town, county, and state)
10. Usual Occupation
11. Industry or business: Associated Transport

FATHER
12. Name: John L. Parks
13. Birthplace: N. C.

MOTHER
14. Maiden Name: Lowella Temple
15. Birthplace: N. C.

16 (a) Informant: Mrs. Maude H. Parks
(b) Address: 1141 Ellicott Driveway

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof: 1/1/46 (month) (day) (year)
(c) Cemetery or crematory: Hopewell Cem.
Location: Mecklenburg Co., N. C.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

(a) Date received by registrar: JAN 1 1946 (b) [illegible] Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12/30/45, 19, at 11:45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH: Shock

Due to: Bullet Wound (.22 Caliber) Rt. temple

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury: 12/30/45 8:30 P. M.
(b) Where did injury occur? 1141 Ellicott Drive
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work?
(d) Means of injury: Self Inflicted

23. Signature: [signature] M.D. (Medical Examiner.)
Date signed: 12/31/45

G35809

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G35809 Registered No. 170c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Towson
(If outside city or town limits, write RURAL and give town)
(d) Street No. 104 Centre Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ruth H. Rankin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	Widow

6 (b) Name of husband ~~or wife~~ John Rankin
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 4 1876.

8. AGE: Years	Months	Days	If less than one day
69	9	26	hr. min.

9. Birthplace Frostburg Md.
(Town, county, and state)

10. Usual Occupation Home Wife

11. Industry or business

FATHER
12. Name 3
13. Birthplace 1

MOTHER
14. Maiden Name Elizer Stevens
15. Birthplace England

16 (a) Informant Mrs Martha Poff.
(b) Address 104 Centre Ave. Towson

17 (a) Burial (b) Date thereof 1/2/1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Allegheny Com
Location Frostburg Md.

18 (a) Funeral director Howard A. Gill
(b) Address 19 W. Penna Ave. Towson

19 (a) (b)
(Date rec'd by registrar) (Registrar)

JAN 3 1946
VS 101

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 30 1945, at 1 P.M

21. I certify that I took charge of the remains described above, held an Autopsy & Inq thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Skull fracture.
Intracranial hemorrhage.
Fractured jaw, & fracture
Due to of left femur

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12/29/45 27/12 ~~7:30~~ Med P.M.
(b) Where did injury occur? Lake ave & Yorkhill
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Collision Auto & Truck

23. Signature Benedict Skiatalis M.D.
Medical Examiner.

Date signed 12-30-45

0 X

G35810

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

10

G35810 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Herring Run & Harford Rd.
(c) Hospital or institution: Sydenham Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 6 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 310 N. Greene St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Ralph Medford Webb

3 (b) If veteran, name war —
3 (c) Social Security Account No. none

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 2, 1915 1930

8. AGE: Years 15 | Months 0 | Days 29 | If less than one day hr. min.

9. Birthplace Tangier, Virginia (Town, county and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name James Edward Webb
13. Birthplace Fleeton, Virginia

MOTHER
14. Maiden Name Mary Crockett
15. Birthplace Tangier, Virginia

16 (a) Informant Mrs Edward Webb
(b) Address 310 N Greene St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/2/46 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glen Burnie Md

18 (a) Funeral director Millhorn & Dove
(b) Address 1219 N Fond St

19 (a) JAN 1 1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12-31 1945 at 1 30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-29 1945 to 12-31 1945 and that I last saw him alive on 12-31 1945

Immediate cause of death	Duration
Respiratory Obstruction	
Due to Diphtheria, bull-neck	
Due to	
Other Conditions Microcephaly	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Elijah Spraging M. D.
Address Sydenham Hosp. Date signed 12-31-45

VS 150

Please write the causes of death clearly and legibly. Physicians: please write age is especially important.

G35811 ✓ G35811

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163M

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1815 Bolton St (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Georgia Lee Ridgeway

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: [illegible]

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Clarence F

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 14, 1889

8. AGE: Years 56 | Months 11 | Days 16 | If less than one day hr. min.

9. Birthplace W Va. (Town, county, and state)

10. Usual Occupation Registered Nurse

11. Industry or business Self

FATHER — 12. Name Andrew J Rogers
13. Birthplace W Va

MOTHER — 14. Maiden Name Mary L McGowan
15. Birthplace W Va

16 (a) Informant Addie McElroy
(b) Address 3000 Dunmurray Rd Dundalk

17 Removal (Burial, cremation, or removal) (b) Date thereof 1/1/46 (month) (day) (year)

(c) Cemetery or crematory Mt Union
Location Morgantown W Va

18 (a) Funeral director Philcom Corbin
(b) Address 1219 E Fayette St

19 (a) 1946 (Date rec'd by registrar) (b) Clinton Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 30 / 1945 at 8 P. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH
Asphyxiation due to Carbon monoxide

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12-30-45 at ? M.
(b) Where did injury occur? 1815 Bolton Street (Garage)
(c) Did injury occur at home, on farm, industrial place or in public place? Home Garage While at work? No
(d) Means of injury Carbon monoxide

23. Signature Benedict Skutarelic M.D. Medical Examiner.
Date signed 12-31-45

G35812 ✓ G35812

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1603 Hanover St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1603 Hanover St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Peter Knight

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Anna M. Knight (nee Nickels) 6 (c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) Sept. 27 1865

8. AGE: Years	Months	Days	If less than one day
80	3	3	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Peter Knight
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Elizabeth Sweitzer
15. Birthplace Germany

16 (a) Informant Mrs. Anna M. Knight (Wife)
(b) Address 1603 Hanover St., Balto. 30 Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 2 1946 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Baltimore Md.

18 (a) Funeral director C. Howard Evans
(b) Address 1400 S. Charles St. (30)

19 (a) (Date received by registrar) (b) Registrar

JAN 1 1946

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 30, 1945 at 2:00 A. M.

21. I certify that death occurred on the date above stated, that I attended deceased from 12-24-1944 to 12-30-1945 and that I last saw h[illegible] alive on 12/29/1945.

Immediate cause of death	Duration
(a) Cardiac thrombosis	1 day
Due to (b) Uremia & Senility	6 mos
Due to (c)	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 1603 Hanover St. Date signed 1/3/46

G35813

BALTIMORE CITY HEALTH DEPARTMENT ✓ G35813
Registered No.

CERTIFICATE OF DEATH 97

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 11 E. FRANKLIN ST
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 15 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. H E. FRANKLIN ST
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GORA ADELADE COCHRAN

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	WIDOWED

6 (b) Name of husband or wife CHIPEORD COCHRAN
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JAN 13, 1864

8. AGE: Years	Months	Days	If less than one day
81	11	17 18	hr. min.

9. Birthplace FREDERICK CO. MD
(Town, county, and state)
10. Usual Occupation AT HOME
11. Industry or business

FATHER
12. Name NELSON STOCKMAN
13. Birthplace MARY LAND

MOTHER
14. Maiden Name AMANDA BISER
15. Birthplace MARY LAND

16 (a) Informant HELEN COCHRAN
(b) Address 11 E. FRANKLIN ST

17 (a) BURIAL (b) Date thereof 1/3/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory JEFFERSON REFORMED
Location JEFFERSON MD.

18 (a) Funeral director M. R. Etchison
(b) Address Frederick Md.

(a) JAN 1 1946 (b) Registrar Huntington for Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 31 1945 at 5:30 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1945, to Dec 1945, and that I last saw her alive on Dec 30 1945

Immediate cause of death	Duration
Respiratory failure	
Due to Generalized Arteriosclerosis & Hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. Woodsalmon M. D.
Address 601 N. Monroe St Date signed 12/31/45

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G35814 BALTIMORE CITY HEALTH DEPARTMENT X ✓G35814
CERTIFICATE OF DEATH 937 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Aves.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 1713 Levering Rd, Elkridge (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bertha Isaacs

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6, 1865

8. AGE: Years 80 | Months 7 | Days 24 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Joseph Isaacs
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah Lucy Sutton
15. Birthplace Md.

16 (a) Informant Mrs. Sunderland (Carrier)
(b) Address 104 S. Rolling Rd. Catonsville

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-2-1946 (month) (day) (year)
(c) Cemetery or crematory Grace Church
Location Elkridge Md.

18 (a) Funeral director F. C. Higinbotham
(b) Address Ellicott City Md.

19 (Date received by registrar) 1946 Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 30 1945 at 8:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/28 1945 to 12/30 1945 and that I last saw h[illegible] alive on 12/30 1945.

Immediate cause of death: Acute Cardiac Collapse — Duration
Due to Chronic arteriosclerosis C-V-D.
Due to
Other Conditions Right upper lobe pneumonia
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Cliff Patrick, M.D.
Address St. Agnes Hosp. Date signed 12/30/46

VS 150

X

G35815

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G35815

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 45 E Barney St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 45 E. Barney (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Amos Hawkins

3 (b) If veteran, name war: FR.
3 (c) Social Security Account No. 215-10-9599

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W.	Married

6 (b) Name of husband or wife M. Katherine Hall
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/16/879.

8. AGE: Years	Months	Days	If less than one day
66	10	13	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Crane Operator
11. Industry or business

FATHER
12. Name Wm Hawkins
13. Birthplace Md

MOTHER
14. Maiden Name Hannah Carr
15. Birthplace Md.

16 (a) Informant Mrs M. E. Hawkins
(b) Address 45 E Barney St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/2/46. (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Russell & Highway
18 (a) Funeral director J. J. Foley & Son
(b) Address 1218 Eutaw St
19 (a) Filed (Date rec'd by registrar) Thos. Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 24 1945, at 6:30 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from Dec 12 1945, to Dec 24 1945, and that I last saw h alive on Dec 24 1945.

Immediate cause of death	Duration
Myocardial Insufficiency	
Due to	
Due to	
Other Conditions Arteriosclerosis Hypertension & Myocarditis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: —
—
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John G. Schwenk M.D.
Address 1307 S. Charles St Date signed 12/30/45

1946
VS 150

I correct age is especially important. Physicians: please write the ... every item of information should be carefully supplied. Use the causes of death clearly and legibly.

AB-93226 G35816

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G35816 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8mos. 7days
(e) Length of stay in Baltimore (yrs., mos., or days) 50yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 908 Brevard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Edward Downey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Christiana (D)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 20-? 187?

8. AGE: Years 71? Months 8 Days 20? If less than one day hr. min.

9. Birthplace N.C. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Samuel (D)
13. Birthplace N.C.

MOTHER
14. Maiden Name Isabell ? (D)
15. Birthplace N.C.

16 (a) Informant Baltimore City Hospitals (Records)
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 1, 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Baltimore Co. Md.

18 (a) Funeral director Chas. Sloan & Co. Inc.
(b) Address 1631 Druid Hill Ave.

19 (a) (Date received by registrar) (b)

JAN - 1 1946

Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 27- 1945, at 10.50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-20- 1945 to 12-27- 1945 and that I last saw h. in alive on 12-27- 1945

Immediate cause of death Bronchopneumonia

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations: none

of autopsy: same as above

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature T. P. Jerrigan M. D.
Address Baltimore City Hosp. Date signed 12-29-45

X

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

A443 [illegible]635817 BALTIMORE CITY HEALTH DEPARTMENT ✓ 635817
CERTIFICATE OF DEATH 6 Registered No.

Write the causes of death clearly and legibly. Correct age is especially important. Physicians: please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1317 N. Port, St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas [illegible] Creamer ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 17-1944

8. AGE: Years	Months	Days	If less than one day
1	9	13	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Morris [illegible] Creamer
13. Birthplace Md.

MOTHER
14. Maiden Name Dorothy Cook
15. Birthplace Md

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 2-46 (month) (day) (year)
(c) Cemetery or crematory Balto. Lem.
Location North Ave. + Gay St.

18 (a) Funeral director John G. Miller
(b) Address 2324 Jefferson St.

19 (a) JAN 1 1946 (Date received by local registrar) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 29 19 45 at 10 40 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-29 19 45 to 12-29 19 45
and that I last saw h[illegible] alive on 12-29 19 45

Immediate cause of death	Duration
Meningococcemia	
Bilateral Adrenal Insufficiency	1 day
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
Biopsy
of autopsy: Bilateral Adrenal Hemorrhage

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter M. Tarsem M. D.
Address J. H. H. Date signed 12-29-45

X

G35818 BIEN ✓G35818

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto. General Hospital 15

(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3104 Westwood Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM J BIEN Sr

3 (b) If veteran, name war

3 (c) Social Security Account No. 243-03-2566

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Anna M. Bien

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 27-1884

8. AGE: Years	Months	Days	If less than one day
57	8	2	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Foreman Photo Eng. Dept.
11. Industry or business for Sun.

FATHER
12. Name Henry Bien
13. Birthplace Baltimore

MOTHER
14. Maiden Name Elizabeth Fingerdenburg
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Anna M. Bien
(b) Address 3104 Westwood ave

17 (a) Burial (b) Date thereof Jan 2-1946
(Burial, cremation, or removal) (Month) (day) (year)
(c) Cemetery or crematory Leuden Park Cem
Location Baltimore Md

18 (a) Funeral director Mamie Cook Byfer
(b) Address 1600 N. North ave

1946

19 (a) (Date rec'd by Registrar) (b) Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH December 29, 1945, at 9:35 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion —

Due to

Other Conditions —

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J Helfrich M.D.
Medical Examiner.
Date signed 29 Dec 45

635819 BALTIMORE CITY HEALTH DEPARTMENT ✓ 635819
CERTIFICATE OF DEATH 94a Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4008 W. Garrison Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 d
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits write RURAL and give town)
(d) Street No. 4008 W. Garrison Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SOLOMON ROSENBERG

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Sarah

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1865

8. AGE: Years 80 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Aaron

13. Birthplace Russia

MOTHER 14. Maiden Name Baula

15. Birthplace

16 (a) Informant Henry I. Rosenberg

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-1-46 (month) (day) (year)

(c) Cemetery or crematory Rosedale

Location Philadelphia Rd & Hamilton Ave

18 (a) Funeral director Jack Louis Inc

(b) Address 1432 E. Balto St.

19 (a) (b) Huntington Ave Baltimore

JAN 1 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/31/45 19..., at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1943 19... to Dec 31 1945, and that I last saw him alive on 12/30 1945.

Immediate cause of death Coronary Thrombosis — Duration 2 yr

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. Chodoff M. D.

Address 225 Linden Ave Date signed 1/1/46

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G35820

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G35820 Registered No. 160 a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St.
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2254 Linden Av.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Goodman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex female

5. Color or race white

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ✓

8. AGE: Years | Months | Days 215 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Isaac Goodman

13. Birthplace Russia

MOTHER 14. Maiden Name Helen Katz Goodman

15. Birthplace Russia

16 (a) Informant Mrs. Goodman

(b) Address 2254 Linden Av.

17 (a) Burial (b) Date thereof 1-1-46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mosheir Israel

Location Southern Ave

18 (a) Funeral director Jack Lewis Inc

(b) Address 2106 Eutaw Place

19 (a) (b)
(Signature of local registrar)

JAN 1 1946

Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 1, 1946 at 1:35 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19.

Immediate cause of death: cerebral hemorrhage
Terminal Coma.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Irwin Sommers M. D.

Address Sinai Hospital Date signed 1-1-46

X

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

G35821 ✓ G35821

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 109a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green St.
(c) Hospital or institution: Emmanuel Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hr.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Harford
(c) City or town Aberdeen Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jeanne Baker. ✓
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex F
5. Color or race W
6 (a) Single, married, widowed, or divorced Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Dec 24, 1945
8. AGE: Years | Months | Days 8 7 | If less than one day hr. min.
9. Birthplace Md (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Marvin Baker
13. Birthplace Md

MOTHER
14. Maiden Name Josephine Harbes
15. Birthplace Md

16 (a) Informant Hospital Records
(b) Address Redwood & Green St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 2/46 (month) (day) (year)
(c) Cemetery or crematory Smith Chapel
Location Harford Co.
18 (a) Funeral director John C. Mitchell & Sons
(b) Address 1900 Eastern Pk.
19 (a) (Date rec'd by registrar) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/31/45 at 10:50 P M
21. I certify that death occurred on the date above stated; that I attended deceased from 12/31/45 to 12/31/45 and that I last saw h alive on 12/31/45
Immediate cause of death Resp. Failure — Duration
Due to Ut. Apical Pneumonia
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Thomas J. Bowers, M.D.
Address Md. Date signed 1/3/46

Correct age is especially important. Physicians: please write the

1946

VS 150

G35822 ✓ G35822

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No.

Write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Born here
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 927 Grindall St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henrietta Gardner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: C

6 (a) Single, married, widowed, or divorced: W

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1888

8. AGE: Years: 57 | Months | Days | If less than one day: hr. min.

9. Birthplace Gettysburg, Pa. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Charles Gardener
(b) Address 1604 E. Monument St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/2/45 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brentley ave

19 (a) (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

JAN 1 1946
VS 15T

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/27 1945 at 9:00 A.M.

21. I certify that I took charge of the remains described above, held an Inspection-Inquest (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature C. P. Lubinski M.D. Medical Examiner.
Date signed 12/29/45

6358:23

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

6358:23

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 522 N. CHESTER ST
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 522 N. CHESTER ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE ZORN

3 (b) If veteran, name war NO

3 (c) Social Security Account No.

4. Sex MALE

5. Color or race WHITE

6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife CATHERINE ZORN

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APR. 20 1880

8. AGE: Years 65 Months 8 Days 9 If less than one day hr. min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)

10. Usual Occupation COOPER

11. Industry or business

FATHER
12. Name LAWRENCE ZORN
13. Birthplace GERMANY

MOTHER
14. Maiden Name BARBARA EMILINE
15. Birthplace GERMANY

16 (a) Informant CATHERINE ZORN (WIFE)
(b) Address 522 N. CHESTER ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JAN. 2/46 (month) (day) (year)
(c) Cemetery or crematory SACRED HEART
Location GERMAN HILL ROAD

18 (a) Funeral director Lilly & Zeiler Inc.
(b) Address 403 S. WOLFE ST.

19 JAN - 2 1946 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH DEC. 29 1945 at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 15 1945 to Dec 29 1945 and that I last saw h[illegible] alive on Dec. 28 1945

Immediate cause of death Acute Cardiac failure — Duration

Due to Coronary sclerosis Coron. Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A B Strauss M.D.
Address 3400 Eldorado Ave. Date signed 12/31/45

X

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35824

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

470

G35824 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Wyman Pk. Drive & 31st St.

(c) Hospital or institution: US Marine Hospital, Balto, Md.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days

(e) Length of stay in Baltimore (yrs., mos., or days) 17 days

2. USUAL RESIDENCE OF DECEASED:

(a) State NY (b) County

(c) City or town New York (If outside city or town limits, write RURAL and give town)

(d) Street No. 50 E. 172nd St. (If rural give location)

(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) **FULL NAME** Sennett, William Joseph

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Elizabeth Sennett

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 29, 1886

8. AGE: Years	Months	Days	If less than one day
59	9	0	hr. min.

9. Birthplace New York, NY (Town, county, and state)

10. Usual Occupation Electrician

11. Industry or business US Marine Hospital, Ellis Island NY

FATHER

12. Name Wm. Sennett

13. Birthplace New York, NY

MOTHER

14. Maiden Name Mathilda Mayer

15. Birthplace New York

16 (a) Informant Records

(b) Address US Marine Hospital, Balto, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 2, 46 (month) (day) (year)

(c) Cemetery or crematory Greenmount Cemetery

Location York Rd.

18 (a) Funeral director Odell Funeral Home Inc.

(b) Address 4644 York Rd. B.D

19 (a) (Date rec'd by registrar) JAN - 2 1946 (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 29 1945, at 1:15A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 12 1945 to Dec. 29 1945 and that I last saw h im alive on Dec. 29 1945

Immediate cause of death Constriction of larynx, subtotal — Duration: UNKNOWN

Due to Carcinoma of larynx

Due to Pneumonia, bronchial, bilateral and terminal — Duration: SEVERAL DAYS

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature John L. Wilson

John L. Wilson, Sr. Surgeon M.D.

Address Clinical Director Date signed 12/31/45

US Marine Hospital, Balto, Md.

635825 ✓ 635825

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95C

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 434 E Lanvale St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 434 E Lanvale St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marie D Richards

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife:
6 (c) If alive, give age: 72 years

7. Birth date of deceased (mo., day, yr.) Dec 29 1890

8. AGE: Years 75 | Months 10 | Days 7 | If less than one day: hr. min.

9. Birthplace Webster Mass
(Town, county, and state)

10. Usual Occupation None
11. Industry or business

FATHER
12. Name Gideon Richards
13. Birthplace Canada

MOTHER
14. Maiden Name Adeline Duprey
15. Birthplace Canada

16 (a) Informant George A Richards
(b) Address 1326 N Chester St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-2-46 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Baltimore Md

18 (a) Funeral director Wilson Cook Inc
(b) Address 1219 E Fort Ave

19 (a) (Signature of Registrar) (b) Date received JAN 2 1946 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 29 1945, at 7:4 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-18- 1945, to 12-29 1945, and that I last saw h[illegible] alive on 12-18 1945.

Immediate cause of death: Edema of lungs — Duration: Unknown

Due to: Heart - insufficiency

Due to: } Unknown to me

Other Conditions: }

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dr. Lore Transott
Address 1 Lan Landy - Apts Date signed 1-7-46

correct age is especially important. Physicians: please write the causes of death clearly and legibly. The information should be carefully supplied. The

G35826

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1700

G35826 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Carney (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Menke

3 (b) If veteran, name war —
3 (c) Social Security Account No.
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower
6 (b) Name of husband or wife: Charlotte
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct 5 1871
8. AGE: Years 74 | Months 2 | Days 26 | If less than one day hr. min.
9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Worked Polishing Lens
11. Industry or business

FATHER
12. Name
13. Birthplace Germany

MOTHER
14. Maiden Name
15. Birthplace Germany

16 (a) Informant Bernhard Menke
(b) Address 6844 Harford Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/5/46 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md.

18 (a) Funeral director Uthoff Conroe
(b) Address 1217 E Oral St

19 (a) (Date received by registrar) JAN 2 1946 (b) Registrar Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 1 1946, at 7:30 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
* Skull fracture
* Contusion of brain
Fracture of tibia and fibula left leg.
Other Conditions Hypostatic Pneumonia
Fractured pelvis
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Dec 23 Balto. Co.
(b) Where did injury occur? Harford Rd near Carney
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no
(d) Means of injury Struck by Auto

23. Signature Benedict DiMarco M.D. Medical Examiner
Date signed 1-1-46

100 N MILTON AVE.
11A3 G35827

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93D

Registered No. G35827

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1403 MARSHALL ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1403 MARSHALL ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EDWARD. J. STYLES

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
—	—	MALE	WHITE	MARRIED

6 (b) Name of husband or wife FRANCES STYLES
6 (c) If alive, give age 7 years

7. Birth date of deceased (mo., day, yr.) JULY 14-1867

8. AGE: Years	Months	Days	If less than one day
78	5	17	hr. min.

9. Birthplace ENGLAND
(Town, county, and state)
10. Usual Occupation SEXTON
11. Industry or business ADVENT CHAPEL CHURCH

FATHER
12. Name EDWARD H. STYLES
13. Birthplace ENGLAND

MOTHER
14. Maiden Name NOT KNOWN
15. Birthplace " "

16 (a) Informant FRANCES STYLES
(b) Address 1403 MARSHALL ST

17 (a) BURIAL (b) Date thereof 1-3-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory CEDAR HILL
Location A.A.Co.

18 (a) Funeral director Bernard C Harle
(b) Address 121 E West St

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH DEC 31st 1945, at 11.50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/4 1945 to 12/31 1945, and that I last saw h alive on 12/21 1945.

Immediate cause of death	Duration
Pulmonary Edema	12 hours
Cardio Vascular Disease	2
Due to arteriosclerosis	2
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature I H J Taylor M. D.
Address 100 W. Mulberry Date signed 1/1/46

VS 150 JAN - 2 1946 Huntington Williams, MD

X

Every item or information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35828

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G35828 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fa... Square Hospital
(c) Hospital or institution: Fayette & Calhoun Sts
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 917 BURGUNDY. ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Barthalow

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: M

5. Color or race: White

6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: Madeline BARTHLO

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) MARCH 15 190

8. AGE: Years 43 | Months 9 | Days 15 | If less than one day ... hr. ... min.

9. Birthplace Winchester, Va. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Orey Barthalow
13. Birthplace Martinsburg Va.

MOTHER
14. Maiden Name LOTTIE Jones
15. Birthplace Greenville, W. Va.

16 (a) Informant MADELINE BARTHALOW
(b) Address 917 BURGUNDY. ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 1-2-1946 (month) (day) (year)
(c) Cemetery or crematory HOLY CROSS
Location A.A.Co.

18 (a) Funeral director Bernard C Harle
(b) Address 121 E West St

19 (a) ... (Date rec'd by registrar) (b) ... Registrar

VS 150 JAN - 2 1946 Huntingtown

96

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-30- 1945, at 6 29 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-27 1945, to 12-30 1945, and that I last saw h. in alive on 12-30-1945

Immediate cause of death	Duration
1. Coron Aneurysm	
Due to	
2.	
Due to	
3.	
Other Conditions Pulmonary Tuberculosis (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature D. K. Kerneman M. D.
Address Franklin Date signed 12-30-45

correct age is especially important. Physicians; please write the causes of death clearly and legibly.

G35829

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13/A

G35829 Registered No.

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1119 Park Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1119 Park Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES A. HICKS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years	Months	Days	If less than one day
66			hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Waiter
11. Industry or business

FATHER
12. Name Jerry Hicks
13. Birthplace Md.

MOTHER
14. Maiden Name Hannah Bander
15. Birthplace Md.

16 (a) Informant Mr. Robert H. Hicks
(b) Address 2223 Etting St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-3-46 (month) (day) (year)
(c) Cemetery or crematory St. Peters Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) JAN 2 1946 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 29 1945, at 6:15P

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 19 44 to 12-29 1945 and that I last saw h[illegible] alive on 12-29 1945

Immediate cause of death

Due to Cardio Vascular Renal Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address 2033 Eutaw Place Date signed 1/7/1946

X

G35830

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G35830 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4456 Falls Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Browne
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Female
5. Color or race Black
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife George
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 5-7-75
8. AGE: Years 70 Months 7 Days If less than one day hr. min.
9. Birthplace Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business
FATHER 12. Name Culet Browne
13. Birthplace Md
MOTHER 14. Maiden Name Mary F Oliver
15. Birthplace Md
16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL
17 (a) Burial (b) Date thereof 1-2-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore CO., Md.
18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle Stt
19 (a) (Date rec'd by registrar) (b) Registrar
JAN - 2 1946
Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 29 1945, at 6 20 M
21. I certify that death occurred on the date above stated; that I attended deceased from Dec 19 1945 to Dec 29 1945 and that I last saw her alive on Dec 29 1945.

	Duration
Immediate cause of death Hypertensive cardio vascular disease with cerebral hemorrhage	5 YRS 2 DAYS
Due to	
Due to	
Other Conditions Hypostatic terminal pneumonia	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: confirmed above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature S.P. Asper Jr. M. D.
Address Johns Hopkins Hosp. Date signed Dec 30, 1945

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

AB-98156 G35831

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G35831 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County BALTO.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1706 E. Pratt St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Bangert

3 (b) If veteran, name war: W.W.# 1

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Hilda A. BANGERT

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 31-1896

8. AGE: Years 49 | Months 6 | Days 29 | If less than one day ... hr. ... min.

9. Birthplace Md. BALTO.
(Town, county, and state)

10. Usual Occupation SPARROWS POINT

11. Industry or business STEEL MILL

FATHER
12. Name ? JOSEPH BANGERT
13. Birthplace ? BALTO.MD.

MOTHER
14. Maiden Name ?ANNA REICKERT
15. Birthplace ?BALTO.MD.

16 (a) Informant Baltimore City Hospitals(Records
(b) Address 4940 Eastern Ave.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JAN.2/46 (month) (day) (year)
(c) Cemetery or crematory OAK LAWN
Location EASTERN AVE.EXT.

18 (a) Funeral director Leibzeiter inc.
(b) Address 403 S.WOLFE ST.

19 (a) Filed (b) Registrar
JAN 2 1946 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 30- 1945 at 1.10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-29 19 45 to 12-30- 19 45 and that I last saw h... alive on 12-30- 19 45.

Immediate cause of death: Cerebralvascular accident — Duration

Due to: Hypertensive Cardio-vascular disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Intervascular H.C.V.D. Cardiac hypertrophy

of autopsy

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Margaret M. Davis
Address B. C. H. Date signed 12/31/45

PHYSICIAN
Underline the cause to which death should be charged statistically.

X

Please write plainly, with ONE ENTRY IN EACH SPACE. Every item or information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G358.32

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G358832

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline & Oliver Sts
(c) Hospital or institution:
St. Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Harford
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. Joppa Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country No

3 (a) FULL NAME Mrs. Marie A. Geier (Geier)

3 (b) If veteran, name war: No

3 (c) Social Security Account No.:

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Robert K Geier
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 20 1888

8. AGE: Years 57 | Months 6 | Days 10 11 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Conrad C Hohl
13. Birthplace Germany

MOTHER
14. Maiden Name Amalia Mateses
15. Birthplace Germany

16 (a) Informant Robert K Geier
(b) Address Joppa Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/4/46 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Woodlawn Md

18 (a) Funeral director Lassahn Funeral Home
(b) Address 7401 Belair Road

19 (a) JAN 2 1946 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS.150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-1 1946 at 2 15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-29 1945 to 1-1 1946 and that I last saw her alive on 12-31 1945.

Immediate cause of death	Duration
Cardiac Failure	
Due to Cardiac Decompensation	
Due to Arteriosclerotic C-V. disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm F. Frank M. D.
Address c/o St. Jos. Hosp. Date signed 1-7-46

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

G35833

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 830

Registration No. G35833

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2330 madison ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) Life 3
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2330 Madison ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Estella Gantt Nelson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	married

6 (b) Name of husband or wife Harry Nelson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 10, 1889

8. AGE: Years	Months	Days	If less than one day
56	4	19	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name Levi Gantt
13. Birthplace md

MOTHER
14. Maiden Name Annie Herbert
15. Birthplace md

16 (a) Informant Harry Nelson
(b) Address 2330 Madison ave

17 (a) Burial (b) Date thereof Jan 2 - 46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director James Addison
(b) Address 142 W Preston St

19 (a) (b)
(Date rec'd by registrar) Registrar

JAN - 2 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 29 1945 at 1.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1945 to Dec 29 1945
and that I last saw h alive on Dec 29 1945

Immediate cause of death Cerebral Hemorrhage — Duration

Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm A Hankins M. D.
Address 142 W Preston St Date signed

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35834

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No. G35834

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 318 E. 25th St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md, (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 318 E. 25th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: MARY ESTELLE AUBREY

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: James Louis Aubrey

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Dec. 25, 1860

8. AGE: Years 85 | Months 0 | Days 5 | If less than one day ... hr. ... min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Joseph Hughes
13. Birthplace

MOTHER
14. Maiden Name: Mary Jane ?
15. Birthplace

16 (a) Informant: Mr. Aubrey Maccubbin
(b) Address: 2730 Fenwich Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/2/46 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) JAN - 2 1946 (Date rec'd by registrar) Huntington Hollins, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 30, 1945, at 8:00A M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-10-1944 to 12-30-1945 and that I last saw her alive on 12-29-1945

Immediate cause of death: Chronic cardiorenal disease — Duration: Unknown

Due to: Arteriosclerosis — Duration: Unknown

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Wm. B. Sybert M. D.
Address 1102 Hanford Rd. Date signed 12-31-45

X

VS 180

Information furnished on this certificate is required by law for the registration of deaths, and will be used for statistical purposes only. Therefore, it is important that the information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35835

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G35835

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 519 Edgewood St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 519 Edgewood St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BLANCHE VIOLA COOK

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Charles Philip Cook
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 17, 1877

8. AGE: Years	Months	Days	If less than one day -
68	5	13	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George Washington Slater
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Helen Moore
15. Birthplace Pa.

16 (a) Informant Miss Elizabeth S. Cook
(b) Address 519 Edgewood St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/2/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JAN 2 1946 (Date received by registrar) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 30, 1945, at 4:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 15 1945 to Dec 30 1945 and that I last saw h[illegible] alive on Dec 30 1945

Immediate cause of death Coronary Thrombosis — Duration 30 Minutes
Due to Cardiac Arthritis — 10 yrs
Due to Hypertension — 8 yrs
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 1202 S Paul St Date signed 1/3/46

X Koons

PRINTING IN ITALICS, WITH CAPITAL LETTERS, WILL BE CAREFULLY FOLLOWED. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35836

HB 97873

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

Registered No. G35836

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 70 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1124 Carroll St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Schaum

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Winifred B. Schaum
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 28, 1875

8. AGE: Years	Months	Days	If less than one day
70	2	2	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Motion Picture Operator
11. Industry or business

FATHER
12. Name Lewis J Schaum
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Reather
15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals (Records)
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 1/2/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto. Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JAN - 2 1946 (b) Hunting for Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 30, 1945, at 2:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 14, 1945 to Dec. 30, 1945, and that I last saw him alive on Dec. 30, 1945

Immediate cause of death: Pulmonary Tuberculosis — Duration: 2 months
Due to: Tuberle bacillosis
Due to:
Other Conditions: Tuberculous enteritis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas J. O'Neill M. D.
Address Balto. City Hosps Date signed 12-30-46

X

VS 150

Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35837

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 96C

G35837 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 16 N. Stricker St.
(c) Hospital or institution: 19-2

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 16 N. Stricker St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MATTIE WILKINSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife James H. Wilkinson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 3, 1865

8. AGE: Years	Months	Days	If less than one day
80	10	26	hr. min.

9. Birthplace Philadelphia, Pa.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Kilgour
13. Birthplace England

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mr. William F. Turnbaugh
(b) Address 16 N. Stricker St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/2/46 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JAN - 2 1946 (Date rec'd by registrar) Huntington (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 29, 19 45 at 10:00 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from on above date to 19, and that I last saw h alive on 19

Immediate cause of death — Duration
Heart Disease — 1-3 years
Due to ? — 2
Due to ?
Other Conditions Senility
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. R. Cameron M. D.
Address 413 St Paul Place Date signed Jan 2/45

X

G35838

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. G35838

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 829 Edmondson ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 12 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 829 Edmondson Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Linton Ross

3 (b) If veteran, name war: World War #2

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1912

8. AGE: Years 33 | Months | Days | If less than one day hr. min.

9. Birthplace South Carolina (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Will Ross
13. Birthplace S.C

MOTHER
14. Maiden Name Louise Ross
15. Birthplace S.C.

16 (a) Informant Tony Ross
(b) Address 904 W. Mulberry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/3/46 (month) (day) (year)
(c) Cemetery or crematory Wm
Location Winnsboro, S.C.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Stanley ave
(c) (Date rec'd by registrar) JAN - 2 1946 Huntington Woods Md.

Dec. 30, 1945 **MEDICAL CERTIFICATION** 12 H 5 AM

20. DATE OF DEATH 12/30/45, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/16/45 19 to 12/30/45, and that I last saw him alive on 12/27/45

Immediate cause of death: Bronchial Pneumonia — Duration 3 Days
Due to: Heart Disease
Due to: Bronchial Pneumonia
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. Be Ellis
Address 904 Mulberry Date signed 1/2/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G35839

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48B

G35839 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 931 W. Fayette st.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 931 W. Fayette St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Eliza Harris

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Col. | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Edward Harris
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 4, 1878

8. AGE: Years 67 | Months 11 | Days 26 | If less than one day hr. min.

9. Birthplace A. A. Co. Md. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name unknown
13. Birthplace "

MOTHER
14. Maiden Name Isabella Jackson
15. Birthplace md

16 (a) Informant Viola Branch
(b) Address 127 W. Hill St.

17 (a) Burial (b) Date thereof 11/3/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Elroy A. Wilson
(b) Address 900 Bluntley Ave

19 (a) JAN - 2 1946 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION Dec-30, 1945 9.45 A.

20. DATE OF DEATH 12/30/45, 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/30/45 19 12/30/45, and that I last saw her alive on 12/30/45

Immediate cause of death Cerebral hemorrhage

Duration: 2 c

Due to Old age

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Lee Ellis M. D.
Address 1 W Fayette Ave Date signed 1/6

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

635840

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. 635840

1. PLACE OF DEATH: 1916 Mosher St.
(a) Baltimore City, Maryland
(b) Street address 1916 Mosher St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1916 Mosher St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William Henry Miller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Rachel O. Miller
6 (c) If alive, give age 76 years

7. Birth date of deceased (mo., day, yr.) Oct. 14, 1857

8. AGE: Years	Months	Days	If less than one day
88	2	16	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Tinner & Roofer
11. Industry or business

FATHER
12. Name Wm. H. Miller
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Agnes Lamb
15. Birthplace Baltimore Md.

16 (a) Informant Rachel O. Miller
(b) Address 1916 Mosher St.

17 (a) Burial (b) Date thereof Jan. 3 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md.

18 (a) Funeral director George Weber & Son
(b) Address 2563 Edmondson Ave.
(c) Huntington Williams M.D.

JAN - 2 1946
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 30 1945; at 3 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 28 1945 to Dec 30 1945; and that I last saw h in alive Dec 30 1945.

Immediate cause of death Cardiac Arrhest — Duration 4 hr.

Due to Virus Pneumia — 24 hrs

Due to Broncho Pneumia

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. V. Toomey M.D.

Address 222 S Paul St Date signed 1/31/46 M. D.

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. Use ... WITH CARBON INK.

G3581 BALTIMORE CITY HEALTH DEPARTMENT G3581

CERTIFICATE OF DEATH 93D

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4130 Roland Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 4130 Roland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah R. Medcalf Sarah R. Medcalf

3 (b) If veteran, name war V

3 (c) Social Security Account No. C

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1872

8. AGE: Years 73 | Months 10 | Days | If less than one day hr. min. 72

9. Birthplace Balto. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Lewis Medcalf
13. Birthplace Balto.

MOTHER 14. Maiden Name Margaret E. McClanahan
15. Birthplace Balto.

16 (a) Informant Geo. W. Fitzpatrick
(b) Address 427 Fairfield Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 2/46 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Greenmount Ave & Oliver St.

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 1900 Eutaw Place

19 (a) (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 29 1945 at 2:15 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Atherosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature John R. Divers M.D.
Medical Examiner.
Date signed 12/29/45

G35842

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1312

Registered No. G35842

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 250 N. PINE STREET
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 250 N. PINE STREET
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FANNIE BROWN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	COLORED	WIDOWED

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY, 4, 1898

8. AGE: Years	Months	Days	If less than one day
67 68	5	24 25	hr. min.

9. Birthplace MARYLAND (Town, county, and state)
10. Usual Occupation HOUSEWORK
11. Industry or business

FATHER
12. Name JOHN BRADFORD
13. Birthplace MARYLAND

MOTHER
14. Maiden Name JAMIE JOHNSON
15. Birthplace MARYLAND

16 (a) Informant SADIE BROWN
(b) Address 250 N. PINE STREET

17 (a) BURIAL (b) Date thereof I-2-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory MT. CALVARY
Location ANNE ARUNDEL, CO, MD.

18 (a) Funeral director WILLIAM A. JACKSON
(b) Address 916 PENNA,. AVE,

19 (a) (Date rec'd by registrar) (b) [illegible]

JAN - 2 1946

VS-450

MEDICAL CERTIFICATION

20. DATE OF DEATH DECEMBER 29 1945 at 86 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/25 1945 to 12/29 1945 and that I last saw h[illegible] alive on 12/29 1945.

Immediate cause of death Cerebral Hemorrhage

Due to Hypertension

Due to Chronic endocarditis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: 1 Day

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address [illegible] M. D.
Date signed 1/7/46

correct age is especially important. Physicians: please write the

G35843 | BALTIMORE CITY HEALTH DEPARTMENT | G35843

CERTIFICATE OF DEATH 1572

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution:
Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 157 N. Decker Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Boy Sifford

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 26-45

8. AGE: Years	Months	Days	If less than one day
		5	hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Benjamin Sifford
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Naomi A. Baker
15. Birthplace Baltimore, Md

16 (a) Informant Naomi Sifford
(b) Address 157 N. Decker Ave

17 (a) Burial (b) Date thereof Jan. 2-45
(Burial, cremation, or removal) (day) (year)
(c) Cemetery or crematory Oak Grove
Location Eastern Ave Rd

18 (a) Funeral director Thos. O. Hogan
(b) Address 3004 E. Balto. St

19 (a) (b) Huntington Williams M.D.
(Signature of Registrar)
Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH December 31, 19 45, at 12 M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19
and that I last saw h alive on 19

Immediate cause of death congenital heart
= bronchopneumonia

	Duration
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Irwin Dennan, M.D.
M. D.
Address Sinai Hosp. Date signed 1-1-46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35844

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

830

G35844 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 157 N Linwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 157 N Linwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anna Heindl

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 16 1883

8. AGE: Years	Months	Days	If less than one day
62	7 M.	15	hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER
12. Name John Heindl
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Rohgls
15. Birthplace Germany

16 (a) Informant Marie Fedahn
(b) Address 156 N Linwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 3 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director [illegible] Moran
(b) Address 3000 Baltimore St

19 (a) (Sign like 4-day registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 31 1945 at 2:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 1941, to Dec 31 1945, and that I last saw her alive on Dec 31 1945

Immediate cause of death
ARTERIOSCLEROSIS — Duration 3 Yrs

Due to LYMPHATIC PSIOD. — 2 Yrs

Due to

Other Conditions CEREBRAL HEMORRHAGE — 5 DAYS

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James T Kavanagh M.D.
Address 1324 W Baltimore St Date signed M. D. 12-31-45

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1 Fem G35845

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 85D

Registered No. G35845

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3303 Hayward Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3303 Hayward Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Thomas Mc Mahon

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-01-1412

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced:
Male	White	Married

6 (b) Name of husband or wife Essie E. McMahon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 15, 1873

8. AGE: Years	Months	Days	If less than one day
72	5	15	hr. min.

9. Birthplace Balto Co; Md.
(Town, county, and state)

10. Usual Occupation Retired
11. Industry or business Machinist

FATHER
12. Name Patrick Mc Mahon
13. Birthplace Ireland

MOTHER
14. Maiden Name Anna Rebhein
15. Birthplace Balto

16 (a) Informant Mrs. B. J. Callahan
(b) Address 3303 Hayward Ave

17 (a) Burial (b) Date thereof 1-3-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore, Md

18 (a) Funeral director Forney Byers
(b) Address 5005 Park Heights Ave

19 (a) (b)
(Date received by registrar) (Registrar)

JAN 2 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 30 1945; at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1945 to Dec 30 1945 and that I last saw him alive on Dec 30 1945.

Immediate cause of death	Duration
Uremic plegia	2 days
Due to Bronchopneumonia	4 days
Due to Senility	
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operations: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury

23. Signature Chas. A. J. Freese M. D.
Address 5276 Park Heights Date signed Jan 1 46

X

correct age is especially important. Physicians: Please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

G35826 BALTIMORE CITY HEALTH DEPARTMENT G35826
CERTIFICATE OF DEATH 46 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3722 Oakmont Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3722 Oakmont Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Josef Mayr, 3722 Oakmont Avenue
Joseph Mayer

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Sarah Buckenmeyer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 16, 1863

8. AGE: Years 82 | Months 7 | Days 14 | If less than one day Hr. min. 1867

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Sara Buckenmeyer
(b) Address 3722 Oakmont Ave.

17 (a) Burial (b) Date thereof 1-3-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Thomas J. Bevan
(b) Address 5305 York Rd.

19 JAN - 2 1946 (b) Huntington Williams Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 31 1945 at 9 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Not attended to 19 ; and that I last saw h[illegible] alive on Dec. 31 1945.

Immediate cause of death Cerebral hemorrhage

Due to Cerebral sclerosis

Due to Coronary thrombosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 2 years ago

Major findings of operation: H. Pathology

of autopsy: General

Duration
unknown

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. Hare Tramontt M.D.
Address Lombardy Apartments Date signed 1-1-46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G3587 BALTIMORE CITY HEALTH DEPARTMENT V G3587
92B
CERTIFICATE OF DEATH
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3635 W. Belvedere Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3635 W. Belvedere Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry O. Stidman

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Katherine
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 7, 1880

8. AGE: Years	Months	Days	If less than one day
65	6	13	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Wire Worker
11. Industry or business

FATHER
12. Name John Stidman
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Katherine A. Stidman
(b) Address 3635 W. Belvedere Ave

17 (a) Burial (b) Date thereof 1-2-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md

18 (a) Funeral director Long Bros.
(b) Address 5005 Park Heights Ave

19 (a) JAN - 2 1946 (b)
(Date rec'd by Registrar) Registrar
Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 30 1945, at 12:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 26 1945, to Dec 30 1945, and that I last saw him alive on Dec 28 1945.

Immediate cause of death	Duration
Myocarditis & Mitral regurgitation	5 days
Due to Arterio Sclerosis	5 days
Due to	
Other Conditions Grippe	5 days

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature F. L. de Barbieri M. D.
Address 4723 Park Heights Ave Date signed 1/1/45

F. L. de Barbieri X

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G35848

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. G35848

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1046 N. Central Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1046 N. Central Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alberta Stewart

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	C.	Married

6 (b) Name of husband or wife Curtis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/25/1921

8. AGE: Years	Months	Days	If less than one day
24	-	4	hr. min.

9. Birthplace S. C. (Town, county, and state)
10. Usual Occupation Home wife
11. Industry or business

FATHER
12. Name Leslie Bacon
13. Birthplace S. C.

MOTHER
14. Maiden Name Mabel Simms
15. Birthplace S. C.

16 (a) Informant Curtis Stewart
(b) Address 1046 N. Central Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/2/46 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location

18 (a) Funeral director Joseph B. Locke
(b) Address 1364 N. Central Ave

19 JAN - 2 1946 (Date rec'd by registrar) (b) Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/29 1945, at 11 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/22/45 to 12/29 1945 and that I last saw him alive on 12/29/1945.

Immediate cause of death
Lobar Pneumonia
Due to Jaundice

Duration
1 week 4 days

Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chas. R. Blake M. D.
Address 1327 N. Central Ave
Date signed 12-31-45

G3584 9

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G3584 9 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 516 BRUNSWICK-ST
(c) Hospital or institution: —

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 516 Brunswick St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna L. Mellinis

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4 Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Wm F Mellinis

6 (c) If alive, give age 81 years

7. Birth date of deceased (mo., day, yr.) Nov 11th 1875

8. AGE: Years 70 | Months 2 | Days 20 | If less than one day — hr. — min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business —

FATHER 12. Name Andrew Sobinsky

13. Birthplace Germany

MOTHER 14. Maiden Name Christina Fleischer

15. Birthplace Germany

16 (a) Informant Wilhelmina L. Mellinis

(b) Address 516 Brunswick St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 2-46 (month) (day) (year)

(c) Cemetery or Crematory Loudon Park

Location Baltimore Md.

18 (a) Funeral director J. F. Wagner & Son

(b) Address 660 N. Eutaw St

19 (a) (Date rec'd by registrar) (b) Registrar

vs JAN - 2 1946

Huntington Williams, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 31st 1945 at 3:2 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1945 to Dec 30 1945, and that I last saw h. alive on Dec 30 1945.

Immediate cause of death	Duration
Acute Cardiac Dilatation	2 days
Due to Hypertensive Cardio Vascular disease	3
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry Glassman M. D.

Address 2612 Madison Ave Date signed Dec 31/45

X

Mc LAUGHLIN

635850

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

635850 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1446 Smith Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1446 Smith Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles H. Sullivan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Edith A. Sullivan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 25, 1887

8. AGE: Years	Months	Days	If less than one day
58	1	27	hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation

11. Industry or business Tavern Business

FATHER
12. Name Charles H. Sullivan
13. Birthplace Ireland.

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs. Edith A. Sullivan
(b) Address 1446 Smith Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-24-45 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn, Maryland

18 (a) Funeral director George Byers
(b) Address 5005 Park Heights Ave.

19 (a) Date rec'd by registrar DEC 27 1945 (b) Registered number

JAN - 2 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-24 1945 at 11 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1 1945 to Dec 24 1945 and that I last saw h[illegible] alive on Dec 24 1945

Immediate cause of death Pulmonary Edema
acute Dilatation

Duration
a few hrs
5 years
5 "

Due to Hypertonic Chr

Due to Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edwin H. Mayer
Address The Esplanade Date signed 12/28/45

Edwin Mayer X

Please write plainly, with pen and ink. Every item of information should be carefully considered before answering. Be sure to give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35851

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

G35851 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Glyndon
(If outside city or town limits, write RURAL and give town)
(d) Street No. Central Ave
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Mr. M. Willard McKenney.

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife Mary E. McKenney
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 11 1867

8. AGE: Years	Months	Days	If less than one day
78	9	22	hr. min.

9. Birthplace Anne Arundel Co.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Samuel McKenney
13. Birthplace Md

MOTHER
14. Maiden Name Eliza Hebb
15. Birthplace Md

16 (a) Informant Mortimer McKenney
(b) Address Glyndon

17 (a) Burial (b) Date thereof Jan 5-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory All Saints
Location Reisterstown Md

18 (a) Funeral director J. F. Shirey & Sons
(b) Address Reisterstown Md

19 (a) JAN - 2 1946 Hunting for Willard Hall
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/1/46 19 , at 7:50A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-1-46 19 , to 1-2-46 19 , and that I last saw him alive on 1-2-46 19 .

Immediate cause of death Hemorrhage from Esoph. varicies Causing acute congestive failure.

Due to Cirrhosis of the Liver

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Rachael O. Hoover M. D.
Address Mercy Hosp Date signed 1-2-46

VS 2

G35852

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1312

G35852 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland ✓

(b) Street address

(c) Hospital or institution: University Hospital 15

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1512 Freestman

(If rural give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

3 (a) FULL NAME William Fowlkes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col	Married

6 (b) Name of husband or wife Priscilla

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/3 1877

8. AGE: Years	Months	Days	If less than one day
48	9	26	hr. min.

9. Birthplace Va

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Willie Martin

13. Birthplace Va

MOTHER 14. Maiden Name Emma Fowlkes

15. Birthplace Va

16 (a) Informant Priscilla Fowlkes

(b) Address 1512 Freastman St

17 (a) Burial (b) Date thereof 1/4/46

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Arbutus

Location Md.

18 (a) Funeral director Geo. H. Gelsin

(b) Address 1303 Freastman St

19 (a) (b)

(Date rec'd by registrar) JAN - 2 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-1 1946, at 9:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-31 1945 to 1-1 1946, and that I last saw him alive on 1-1 1946

Immediate cause of death Pneumonitis — Duration

Due to Tuberculosis (?)

Due to

Other Conditions ?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature J. W. Mar M. D.

Address University Hospital Date signed 1-2-46

X

G35853

HEALTH DEPARTMENT—CITY OF BALTIMORE

G35853

CERTIFICATE OF DEATH 92D

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 529 W. Hoffman St Ward) V

Length of residence in city or where death occurred.....yrs.....mos.....ds. How long in U. S. If of foreign birth?.....yrs.....mos.....ds.

2. FULL NAME [redacted] Catherine Saunders

If U.S. Veteran specify WAR .....

(a) Residence: No. 529 Hoffman St Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Fem	Col.	Widow

3a. If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. Saunders

6. DATE OF BIRTH (month, day, year) unknown

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
78	-	-	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Domestic

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Balto.

FATHER

13. NAME Thomas Jones

14. BIRTHPLACE (city or town) (State or country) Md.

MOTHER

15. MAIDEN NAME Rebecca Galloway

16. BIRTHPLACE (city or town) (State or country) Md.

17. INFORMANT Jenny Jones
(Address) 529 Hoffman St

18. BURIAL, CREMATION, OR REMOVAL
Place Mt Auburn Date 1/2/ 1946

19. UNDERTAKER Isaiah F. Brown & Son
(Address) 108 W Montgomery St

20. FILED ..... 19 ..... Huntington for Williams
Registrar.

JAN - 2 1946

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Dec 29, 1945

22. I HEREBY CERTIFY, That I attended deceased from Dec. 20, 1945 to Dec. 29, 1945

I last saw h[redacted] alive on Dec 28, 1945 Death is said to have occurred on the date stated above, at ....m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Valvular disease of heart	
Other contributory causes of importance:	

Was an operation performed? No Date of.....

For what disease or injury? —

What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ..... 19....

Where did injury occur? .....
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place .....

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? No If so, specify.....

(Signed) Hank Elvagner M. D.

(Address) 2027 Calvert

OCCUPATION is very important. See instructions on back of certificate.

G35854

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓97

G35854 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3079 BELMONT AVE
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3079 BELMONT Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA FORTUNE

3 (b) If veteran, name war	3 (c) Social Security Account No. NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
FEMALE	White	MARRIED

6 (b) Name of husband or wife THOMAS J. FORTUNE
6 (c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) JUNE 22- 1873

8. AGE: Years	Months	Days	If less than one day
72	6	9	hr. min.

9. Birthplace BALTIMORE MD
(Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business

FATHER
12. Name FRANK STERNER
13. Birthplace GERMANY

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant THOMAS J. FORTUNE
(b) Address 3079 BELMONT AVE

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 3- 1946 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location City

18 (a) Funeral director Jeff Carl B.M. Walter
(b) Address Pratt Street

19 (a) JAN - 2 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH DECEMBER 31 1945, at 9 30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 10 19 45 to Dec 31 1945 and that I last saw her alive on Dec 31 19 45.

Immediate cause of death	Duration
(a) Cardiac arrest	2da
Due to (b) Arteriosclerosis	3yrs.
Due to (c) Hypertension	3yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Huntington Williams M.D.
Address 1302 St Paul St Date signed Jan 1/46

G35855

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 D

Registered No. G35855

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 428 S. Payson st
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life time

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 428 S. Payson St.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Annie L. Esway

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race Wh. | 6 (a) Single, married, widowed, or divorced. Widowed.

6 (b) Name of husband or wife Nathan M. Esway
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 4th 1871

8. AGE: Years 74 | Months 7 | Days 26 | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation House work

11. Industry or business —

FATHER
12. Name James H. Jones
13. Birthplace Md

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Mabel Frankton
(b) Address 428 S Payson st

17 (a) (Burial, cremation, or removal) (b) Date thereof 1 2 46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location —

18 (a) Funeral director A. Jones
(b) Address 111 S. Pilmon st

19 JAN - 2 1946 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/30 1945 at 7:04 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/27 1945 to 12/30 1945. and that I last saw her alive on 12/30 1945.

Immediate cause of death Arteriosclerotic Cardiovascular Disease

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration
Last

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Benjamin Miller M.D. M. D.
Address 20 30 Wilkens ave Date signed 1/10/46

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35856

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G35856 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 1043 Mount St
(b) Street address 1043 Mount St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1043 Mount St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Billups

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Thomas Billups
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/11/1874

8. AGE: Years	Months	Days	If less than one day
71	10	18	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name John Lancaster
13. Birthplace Md

MOTHER
14. Maiden Name Sarah Hall
15. Birthplace Md

16 (a) Informant Janie Bannerman
(b) Address 1043 Mount St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 2 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 W. Saratoga St.

19 (a) (b)
(Date received by registrar) Registrar

JAN 2 1946

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/29/1945, at M

21. I certify that death occurred on the date above stated that I attended deceased from 12/26/1945 to 12/29/1945, and that I last saw h alive on 12/27/1945

Immediate cause of death
Cerebral Thrombosis
due to Arteriosclerosis
Duration 3 days

Due to
Duration

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Lee Ellis M. D.
Address 1214 N. Broadway Date signed 12/31/45

G35857 — BALTIMORE CITY HEALTH DEPARTMENT — G35857 Registered No.

CERTIFICATE OF DEATH 93D.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3836 Reisterstown Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15'
(e) Length of stay in Baltimore (yrs., mos., or days) 4 Mo

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3836 Reisterstown Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jane Powell Duntson
3 (b) If veteran, name war
3 (c) Social Security Account No. —
4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife Ellis C. Duntson
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 12-29-1861
8. AGE: Years 83 | Months 11 | Days 27 | If less than one day hr. min.
9. Birthplace Va (Town, county, and state)
10. Usual Occupation None
11. Industry or business
FATHER 12. Name John Powell
13. Birthplace Va.
MOTHER 14. Maiden Name Unknown.
15. Birthplace Va
16 (a) Informant Mrs Grace Rutata
(b) Address 3836 Reisterstown Rd
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-28-45 (month) (day) (year)
(c) Cemetery or crematory White Stone Baptist Ch Cem
Location White Stone Va
18 (a) Funeral director Rendell & Humphreys
(b) Address 6067 Harford Rd
19 (a) (Date rec'd by registrar) (b)

JAN 2 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-26- 1945, at 5A M
21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1944 to Dec 26 1945. and that I last saw Her alive on Dec 25 1945

Immediate cause of death	Duration
(a) Cerebral Hemorrhage	5 days
Due to (b) Hypertension and Cardio-Vascular disease	?
Due to (c)	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature A. P. Vandeventer M. D.
Address 4818 Edmondson Ave Date signed 12/29/45

Huntington

G35858

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G35858 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley State City
(c) Hospital or institution:
Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 mos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country Ireland

3 (a) FULL NAME Kathryn Elwood

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1875

8. AGE: Years	Months	Days	If less than one day
70	9		hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation Waitress
11. Industry or business

FATHER
12. Name Michael Elwood
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Hayden
15. Birthplace Ireland

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley St State City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 5, 1946 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 914 Greenmount Ave

19 (a) JAN - 2 1946 (Date received by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan - 1 1946, at 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 20 - 1945, to Jan 1 - 1946, and that I last saw her alive on Jan 1 - 1946

Immediate cause of death	Duration
Edema Lungs	1 day
Due to Chronic Myocarditis	4 yrs
Due to	
Other Conditions Arteria-Sclerosis	6 yrs

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E Gill Hall M. D.
Address 1631 E North av Date signed 1/2/46

VS 150

B35859

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓107

B35859 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun
(c) Hospital or institution: Franklin Square Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 422 Forst St (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Sam Cimino

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Mary Cimino
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name John Cimino
13. Birthplace Italy

MOTHER
14. Maiden Name Mary Culotta
15. Birthplace Italy

16 (a) Informant Mrs Anna DiFatta
(b) Address 2621 Kirk Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 3, 1946 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem
Location Belair Road

18 (a) Funeral director Joseph Farace Inc.
(b) Address 2019 Bluemount Ave

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 31, 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1945, to Dec 1945, and that I last saw him alive on 12-21-1945.

Immediate cause of death	Duration
Cardiac Failure	
Due to Pneumonia	
Due to	
Other Conditions	over

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation:
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Bobby L. Jones M. D.
Address Hamilton & Hoyt Date signed 1/2/46

VS 15

X

AB-98148 G35860

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1160a

Registered No. G35860

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 308 Bridgeview Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Pearson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 28-1945

8. AGE: Years | Months | Days 2 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Karl Pearson
13. Birthplace Va.

MOTHER
14. Maiden Name Addie Wright
15. Birthplace N.C.

16 (a) Informant Baltimore City Hospitals (Record)
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1. 2. 46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location
18 (a) Funeral director L. Rayner Sanders
(b) Address 1412 E Preston St

19 (a) (Date rec'd by reg'r) (b) Registrar

JAN 2 1946 Huntington Hill

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 30 1945, at 11 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-28-30 1945 to 12-30 1945, and that I last saw h. im alive on 12-30 1945.

Immediate cause of death Respiratory failure — Duration 3 days

Due to Cerebral Hemorrhage

Due to Birth Injury

Other Conditions Congenital Heart Disease

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: Cerebral Hemorrhage & Congenital Heart Disease

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work?
(e) Means of injury

23. Signature Richard E. Dorman M. D.
Address Baltimore City Hosp. Date signed 12/31/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35864

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 109a

G35864 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden Ave
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 819 W. Barre St # 3d
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME August Albert Frey

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-18-3982

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Mary Elizabeth
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 30th 1860

8. AGE: Years	Months	Days	If less than one day
85	-	1	hr. min.

9. Birthplace Washington D. C.
(town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Albert Frey
13. Birthplace Unknown

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Clarence A. Frey
(b) Address 819 W. Barre St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 7, 1946 (month) (day) (year)
(c) Cemetery or ~~crematory~~ London Park
Location Balto, Md.

18 (a) Funeral director Harry H. Lutz Co.
(b) Address 401 Edmondson Ave

19 (a) JAN 2 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 31 1946, at 11:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 24th 1946, to Dec 31st 1946, and that I last saw him alive on Dec 30th 1946

Immediate cause of death Uremia — Duration

Due to Bilateral Adrenal Haemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. E. Gonzalez M. D.
Address Maryland G. Hospital Date signed 12/21/46

X

PRINT NAME, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G358.2

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

G358.2 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3011 E Baltimore St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3011 E Baltimore St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Schoor

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Emma
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 23 1873

8. AGE: Years	Months	Days	If less than one day
72	-	8	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name John Schoor
13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Lewina Kess
15. Birthplace Baltimore Md

16 (a) Informant Emma Schoor
(b) Address 3011 E Baltimore St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) 3 (day) 4 (year) 46
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave Road

18 (a) Funeral director John C Moran
(b) Address 3000 E Baltimore St

19 JAN - 2 1946 (Date rec'd by Reg.) Huntington Williamsport Md

MEDICAL CERTIFICATION A.

20. DATE OF DEATH Dec 31 1945 at 10:45 M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 19 1945 to Dec 31 1945 and that I last saw h[illegible] alive on Dec 31 1945

Immediate cause of death Pneumonia
Coronary Thrombosis
Multiple fibromyelomas

Duration

Due to Leukaemia

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edgar C. Beetham M. D.
Address 3139 E. Baltimore St Date signed 12-31-45

VS 150

G358-3

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1940 Registered No. G358-3

write the causes of death clearly and legibly. Physicians: please write

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4617 Kernwood Ave D.of
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore D.of (If outside city or town limits, write RURAL and give town)
(d) Street No. 4617 Kernwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Schwartz

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife Nellie B
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 28 1876

8. AGE: Years	Months	Days	If less than one day
69	5	3	hr. min.

9. Birthplace Balto. Md (Town, county, and state)
10. Usual Occupation Retired curator
11. Industry or business Johns Hopkins Univ.

FATHER
12. Name Geo. F. Schwartz
13. Birthplace Balto.

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mr. George A Schwartz
(b) Address 1911 Barclay St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-3-46 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto. Md.

18 (a) Funeral director Wm. J. Zeltmann
(b) Address Northern Pk. Ave.

19 (a) JAN 2 1946 Registrar Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/31 1945 at 3:20 P M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [signature] M.D. Medical Examiner.
Date signed 1/3/46

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35856

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 130

G35864

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1121 Hewitt Way
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Fla (b) County Marion
(c) City or town Ocala
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William J. Sheridan

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower
6 (b) Name of husband or wife: Martha E.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): March 29, 1869
8. AGE: Years 76 | Months 8 | Days 27 | If less than one day hr. min.
9. Birthplace Jackson Mich
(Town, county, and state)
10. Usual Occupation None
11. Industry or business
12. Name of Father: Thomas Sheridan
13. Birthplace of Father: Ireland
14. Maiden Name of Mother: Unknown
15. Birthplace of Mother: England
16 (a) Informant: Nellie L. Tyner
(b) Address: 1121 Hewitt Way
17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 12/31/45 (month) (day) (year)
(c) Cemetery or crematory: Ocala
Location: Fla
18 (a) Funeral director: Wilcox Cook Inc.
(b) Address: 1217 St. Paul St.
19 (a) Filed (Date received by Registrar) (b) Registrar: Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 26 1945 at 10:45 A.M.
21. I certify that death occurred on the date above stated; that I attended deceased from Dec 22 1945 to Dec 26 1945 and that I last saw him alive on 26 1945.

	Duration
Immediate cause of death: Uremia following	12 hrs
Due to: Acute Nephritis	4 days
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:
23. Signature: Coral Gordon M. D.
Address: 220 W. Northam Date signed: 12-29-45

VS 150

HEALTH DEPARTMENT—CITY OF BALTIMORE

6358-5 6358-5

CERTIFICATE OF DEATH

1. PLACE OF DEATH Santiago Nursing Home 162B

CITY OF BALTIMORE: (No. 4515 Garrison Boulevard Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred since Childhood yrs. mos. da. How long in U. S. If of foreign birth? yrs. mos. da.

2. FULL NAME Winnie Haughety. 14

If U. S. Veteran specify WAR

(a) Residence: No. 637 W. North Ave. St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, year) Mar. 22. 1859

7. AGE Years	Months	Days	If LESS than 1 day hrs. or min.
86	9	9	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Public School Teacher

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Front Royal, Va.

FATHER

13. NAME Rev. Wm. Thomas Vaughan

14. BIRTHPLACE (city or town) (State or country) Baltimore, Md

MOTHER

15. MAIDEN NAME Jane Grant

16. BIRTHPLACE (city or town) (State or country) Germany

17. INFORMANT Alice D. Burch

(Address) 637 W. North Ave.

18. BURIAL, CREMATION, OR REMOVAL

Place Lauden Park Date Jany 3 19 46

19. UNDERTAKER John G. Mitchell & Son

(Address) 1901 Eutaw Place

20. FILED 19

(Registrar)

OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Dec. 31, 1945

22. I HEREBY CERTIFY, That I attended deceased from Since June, 1941 to Dec 1945

I last saw her alive on Dec. 30 1945. Death is said to have occurred on the date stated above, at 6.45 A.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Infirmities of age	

Other contributory causes of importance:

Was an operation performed? No Date of

For what disease or injury?

Name of operation

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur?

(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) R. E. Daughtery M. D.

(Address) 5909 Park Heights Ave

VS 3 JAN - 2 1946

X

G35866

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

Registered No. G35866

Please write the causes of death clearly and legibly. Physicians: please write the cause of death clearly and legibly. Use typewriter supplies. Ink

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 108 E 25th St
(c) Hospital or institution: at home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 108 E 25th St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME HARRY-WILSON-MOORE (Harry Moore)

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 215-24-0147

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Maude G. Moore

6 (c) If alive, give age: 49 years

7. Birth date of deceased (mo., day, yr.): Sept-2-1890

8. AGE: Years: 55 | Months: 4 | Days: 0 | If less than one day: hr. min.

9. Birthplace: Baltimore Md
(Town, county, and state)

10. Usual Occupation: Salesman

11. Industry or business: Automobiles

FATHER
12. Name: John Moore
13. Birthplace: Ireland

MOTHER
14. Maiden Name: Lucy Frost
15. Birthplace: Baltimore

16 (a) Informant: Mrs Maude G Moore (wife)
(b) Address: 108 E 25 St

17 (a) Burial: (Burial, cremation, or removal) (b) Date thereof: 1-4-46 (month) (day) (year)
(c) Cemetery or crematory: Mt Olivet
Location: Baltimore

18 (a) Funeral director: Stewart & Mayo Co.
(b) Address: 108 W Madison St.

JAN 2 1946 (Date rec'd by Registrar) (b) Huntington Williams, Jr. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/2 1946, at 2:25 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary Disease

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury: at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury:

23. Signature: D. J. Lubinsky M.D.
Medical Examiner.
Date signed 1/7/46

G358:57 — BALTIMORE CITY HEALTH DEPARTMENT — G358:57

CERTIFICATE OF DEATH 82

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & 33 St.
(c) Hospital or institution:
Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State New Jersey (b) County
(c) City or town South Orange
(If outside city or town limits, write RURAL and give town)
(d) Street No. 286 Beech Spring Road
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) **FULL NAME** Robert Harris Hirsch

3 (b) If veteran, name war: no
3 (c) Social Security Account No. none

4. Sex: Male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 5, 1926

8. AGE: Years 19 | Months 5 | Days 27 | If less than one day hr. min.

9. Birthplace New Jersey (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Herbert S. Hirsch
13. Birthplace New York

MOTHER
14. Maiden Name Isabel Harris
15. Birthplace New Jersey

16 (a) Informant Mr. Herbert S. Hirsch (Father)
(b) Address S. Orange - N.J.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 1-4-46 (month) (day) (year)
(c) Cemetery or crematory — ? —
Location Newark - N.J.

18 (a) Funeral director Stewart Morrell Co.
(b) Address 108 W. 60th Ave.

19 (a) (Date rec'd by registrar) (b) Huntington Williams Memorial

JAN. - 2 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH January 1 1946, at 12 40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1946 to Jan 1 1946 and that I last saw him alive on Jan 1 1946

Immediate cause of death Respiratory failure — Duration

Due to Atelectasis and ascending paralysis post-operative

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. H. Garrod III

Address Union Mem. Hosp. Date signed 1/1/46 M.D.

X

G35868

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1642 G35868

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6420 Reisterstown Road
(c) Hospital or institution:
Mount Hope Retreat
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 Mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 4 Mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State Conn. (b) County
(c) City or town Pomfret Centre (If outside city or town limits, write RURAL and give town)
(d) Street No. Mount Hope Retreat (Or other location)
St. Robert Hall College
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME David J. Conroy S.J.

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 6 - 1876

8. AGE: Years	Months	Days	If less than one day
69	5	26	hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation Religious Work

11. Industry or business

FATHER
12. Name Patrick Conroy
13. Birthplace County Mayo - Ireland

MOTHER
14. Maiden Name Bridget Burke
15. Birthplace County Mayo - Ireland

16 (a) Informant records Mt. Hope Retreat
(b) Address 6420 Reisterstown Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-2-45 (month) (day) (year)
(c) Cemetery or crematory — ? —
Location New York, N. Y.

18 (a) Funeral director Stewart & Mowen Company
(b) Address 108 W. North Ave, City

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

JAN 2 1946

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/2 1946 2:40 P.M.

21. I certify that I took charge of the remains described above, held an Inspection - Inquest thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH (a) Asphyxiation due to Strangulation

Due to

Other Conditions Dependency

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1/2/46 at about 1:30 P.M.
(b) Where did injury occur? Mount Hope Retreat
(c) Did injury occur at home, on farm, industrial place, in public place? Mount Hope While at work? No
(d) Means of injury Hanged self with rope

23. Signature J. J. Sullivan M.D.
Medical Examiner.
Date signed 1/2/46

G35869

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 6-0

G35869 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1001 Abbott Court
(c) Hospital or institution: at Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1001 Abbott Court (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mamie C. Kelly

3 (b) If veteran, name war: none
3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Edward J. Kelly
6 (c) If alive, give age 81 years

7. Birth date of deceased (mo., day, yr.) May 8, 1870

8. AGE: Years	Months	Days	If less than one day
75	7	24	23 hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name Joseph Kelly
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Elizabeth Flemming
15. Birthplace Baltimore Md

16 (a) Informant Mr. Edward J. Kelly
(b) Address 1001 Abbott Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 3, 1946 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem
Location 4300 Old Frederick Rd

18 (a) Funeral director Elmer W. Conklin & Son
(b) Address 924 E. Eager St.

19 (a) (Date rec'd by registrar) (b)

JAN 2 1946

Huntington Williams

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 31, 1945, at 12 pm M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1945 to Dec. 27 1945.
and that I last saw h[illegible] alive on Dec. 27 1945.
Immediate cause of death Emaciation

Due to generalized Carcinoma

Due to Cancer of the breast

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration
Short
2 years

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Hare Tramposch M. D.
Address Lombard & Arch Date signed 1-1-46

FOREIGN WHITE PRINCE, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35870

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 61

G35870 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 602 Montgomery St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** William Sanders

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Carrie Sanders

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 17 — 1886

8. AGE: Years 59 | Months 3 | Days 14 | If less than one day hr. min.

9. Birthplace Chester S. Carolina (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Turner Sanders
13. Birthplace Chester S. Carolina

MOTHER 14. Maiden Name —
15. Birthplace S. Carolina

16 (a) Informant Flora Bell Sanders
(b) Address 602 Montgomery St.

17 (a) (Burial, cremation, or removal) (b) Date thereof 1 6 46 (month) (day) (year)
(c) Cemetery or crematory Mt. Calery Amity
Location Balto.

18 (a) Funeral director Walter B. Young
(b) Address 139 W. Hamburg St.

19 (a) Date received JAN 2 1946 (b) Hunting Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-31 1945, at 11 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-31 1945, to 19, and that I last saw him alive on 12-31 1945

Immediate cause of death Sepsis — Duration

Due to ?

Due to ?

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. M. Mace M. D.
Address University Hospital Date signed

VS 150

G35871

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G35871

Please answer all questions as carefully and completely as possible. Print the causes of death clearly and legibly. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 108 E. Montgomery St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 108 E Malgomery St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lena Martin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Boyd Martin

6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) June 10, 1884

8. AGE: Years 61 | Months 6 | Days 20 | If less than one day ..... hr. ..... min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Wm Thomas

13. Birthplace Md.

MOTHER 14. Maiden Name Mary Schroeder

15. Birthplace Md.

16 (a) Informant Mr Boyd Martin

(b) Address 108 E. Montgomery

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/3/46 (month) (day) (year)

(c) Cemetery or crematory Cedar Hill

Location Annapolis Blvd

18 (a) Funeral director John F Denny Doc

(b) Address 714 Light St.

19 JAN - 2 1946 (Date received by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 30 Dec 1945 at 6⁰⁰ P M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio Vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury ..... at ..... M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature William S. Kefauver M.D. (Medical Examiner)

Date signed 31 Dec 45

Huntington Williams, Registrar

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The direct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35872 BALTIMORE CITY HEALTH DEPARTMENT G35872

CERTIFICATE OF DEATH 830

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 407 E. Biddle St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 407 E. Biddle St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Anthony Gatta

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	Married

6 (b) Name of husband or wife Rose Gatta
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 13 1873

8. AGE: Years	Months	Days	If less than one day
72	6	18	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Retired Restaurateur
11. Industry or business

FATHER
12. Name Joseph Gatta
13. Birthplace Italy

MOTHER
14. Maiden Name
15. Birthplace Italy

16 (a) Informant Rose Gatta
(b) Address 407 E. Biddle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 4 1946 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Frank V. Pipitone
(b) Address 2818 E. Baltimore St

19 (a) 1946 (b) Rec'd by registrar Washington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 31st 1945, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1945 to Jan 2 1946, and that I last saw h[illegible] alive on Dec 31 1945

Immediate cause of death: Cerebral accident — Duration

Due to: Hemiplegia

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Bernard Cohen M. D.
Address Marlborough Date signed 1-7-46

X

G35873

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V170C

Registered No. G35873

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Essex
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1A. North Rivendale apts.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Phillip M. Sherwood

3 (b) If veteran, name war: World War I

3 (c) Social Security Account No. 213-10-2467

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Martha

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-4-98

8. AGE: Years 47 | Months | Days 27 | If less than one day hr. min.

9. Birthplace Balto Co Md.
(Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business

FATHER
12. Name Nelson Sherwood
13. Birthplace Balto Md

MOTHER
14. Maiden Name Anna Frank
15. Birthplace Md

16 (a) Informant Martha Sherwood.
(b) Address River dale Apt. Middle River

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 1 3 46 (month) (day) (year)

(c) Cemetery or crematory Parkwood
Location Taylor Ave.

18 (a) Funeral director Samuel Buzdynske
(b) Address 1467 Edmondson Ave (Washington Mausoleum)

19 (a) (Date received by registrar) (b) Registrar

VS-151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 31 1945, at 10 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH: Fracture of neck
Severed Spinal cord

Due to

Other Conditions Compound fract of right leg
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury Dec 31 at 9:30 P.M. 53-00

(b) Where did injury occur? Eastern Ave & Orville Rd

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No

(d) Means of injury Struck by Auto.

23. Signature Benedict Skitarelis M.D.
Medical Examiner.

Date signed 1-1-46

the causes of death clearly and legibly. Physicians: please write

G35874

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 168

Registered No. G35874

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Unknown (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Temple Rumbles / Rumbles

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years	Months	Days	If less than one day
53			hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School NOV 26 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) JAN 2 1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 14 1945, at 7:25 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture Skull,
Fracture of Back
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury November 14 M.
(b) Where did injury occur? 224 N. Gay St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Knocked down stairs
23. Signature Robert Lee Fraser M.D. Medical Examiner.
Date signed Nov. 15 1945

VS 151 Over

168

Please answer all questions as completely as you can. Physicians: please write the causes of death clearly and legibly.

G35875

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G35875

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRINT IN PENCIL, WITH UNFADING INK.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1560 Carswell Street

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) None

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County City

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1560 Carswell Street
(If rural give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie E. Norton

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 218-09-6869

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife: Harry S. Norton

6 (c) If alive, give age: D years

7. Birth date of deceased (mo., day, yr.): Dec. 14, 1884

8. AGE: Years	Months	Days	If less than one day
61	0	17	###### min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation: Cook

11. Industry or business: Salad Dressing Co.

FATHER
12. Name: James Kelley
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Mary Hughes
15. Birthplace: Baltimore, Md.

16 (a) Informant: Mrs. Mirian Parr-Daughter
(b) Address: 1560 Carswell Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 3, 1946 (month) (day) (year)

(c) Cemetery or crematory: Mt Olivet
Location: Frederick Rd, Balto: Md.

18 (a) Funeral director: George J. Ruth, Inc.
(b) Address: 1735 Harford Avenue

19 (a) (Date received by local registrar) (b) Registrar: Washington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 31 1945 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 21 1945 to Dec 31 1946, and that I last saw her alive on Dec 30 1945.

Immediate cause of death	Duration
Cerebral Hemorrhage	10 days
Pulmonary Oedema	
Due to Arterio Sclerosis	10 yrs
Due to Hypertensive Heart Disease	10 yrs
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature: Edw. L. Zimmerman M. D.

Address 1858 Harford Date signed 12-31-46

G35876

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G35876 ✓ 178 A Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-0-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1205 Fulton ave.
(e) Citizen of foreign country? (If rural give location) (Yes or No)
If yes, name country

3 (a) FULL NAME Ella Virginia Vincent ✓

3 (b) If veteran, name war –

3 (c) Social Security Account No. 225-12-2985 –

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: married –

6 (b) Name of husband or wife: Joseph Vincent

6 (c) If alive, give age 28 years

7. Birth date of deceased (mo., day, yr.) 6-4-1915

8. AGE: Years 30 | Months 6 | Days 16 | If less than one day hr. min. 7

9. Birthplace: Virginia (Town, county, and state)

10. Usual Occupation: Domestic

11. Industry or business: Home

FATHER
12. Name: James Spitler
13. Birthplace: Va.

MOTHER
14. Maiden Name: Effie Miller
15. Birthplace: Va.

16 (a) Informant: Joseph Vincent
(b) Address: 120 S. Fulton ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/5/46 (month) (day) (year)
(c) Cemetery or crematory
Location: Winchester Va

18 (a) Funeral director: Frederick A. Cole
(b) Address: 1200 W. Lombard St.

19 (a) 2 1946 (Date received by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-1- 1946, at 6 45 P. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to last death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Asphyxiation

Due to Illuminating Gas

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury January 1 1946 M.
(b) Where did injury occur? 120 S. Fulton Ave
(c) Did injury occur at home, on farm, industrial place, in public place? At home While at work? No
(d) Means of injury: Asphyxiated by illuminating gas

23. Signature Howard J. Uhlenhuth M.D.
Medical Examiner.
Date signed 1-2-46

VS 151

G35877 BALTIMORE CITY HEALTH DEPARTMENT KREINER G35877

CERTIFICATE OF DEATH ✓82a

Registered No.

write the causes of death clearly and legibly. Any entry which is illegible or is apparently important. Physicians: please write

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 7015 DUA Hartford Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2y
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7015 Hartford Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wilhelm (or) William Kreiner

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
no	216-01-1234	M	W	widowed

6 (b) Name of husband or wife Grace
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10 1825

8. AGE: Years	Months	Days	If less than one day
75	7	21	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation cabinet-maker
11. Industry or business

FATHER
12. Name William Kreiner
13. Birthplace Germany

MOTHER
14. Maiden Name Mary ?
15. Birthplace Germany

16 (a) Informant Kathryn Sewell
(b) Address 7015 Hartford Rd.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 1/3/46 (month) (day) (year)
(c) Cemetery or crematory H. Redeemer
Location Belair Rd.

18 (a) Funeral director M. Curtis Digges Sons
(b) Address 409 Cathedral & Mulberry Sts.

19 (a) 1-2-1946 (b) Huntington Williams Registrar
(Date received by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/31 1945, at 12:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection-Inquest and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature P. J. Lubinski M.D.
Medical Examiner.
Date signed 1/2/46

G35878 | BALTIMORE CITY HEALTH DEPARTMENT | G35878

CERTIFICATE OF DEATH 94a

Registered No.

Please write the causes of death clearly and legibly. Use ordinary unprocaic. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 514 N. Payson St (If rural give location)
(e) Citizen of foreign country? yes (Yes or No) If yes, name country Italy

3 (a) FULL NAME Nicholas Berniglia

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Serafina

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 1, 1886

8. AGE: Years	Months	Days	If less than one day
60	-	-	hr. min.

9. Birthplace Salerno Italy (Town, county, and state)

10. Usual Occupation Stone

11. Industry or business

FATHER
12. Name Charles Berniglia
13. Birthplace Italy

MOTHER
14. Maiden Name Rosa Tomasetti
15. Birthplace Italy

16 (a) Informant Salvatore Berniglia
(b) Address 100 N. Monroe St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 3 1946 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto. Md.

18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Marley St

No. 2 1946 (a) (b)
(Date rec'd by registrar) Huntington Williams, Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan - 1 1946 at 2 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Coronary occlusion M

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skitarelic M.D. Medical Examiner.
Date signed 1-2-46

G35879

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G35879

CERTIFICATE OF DEATH 1572 Registered No.

Please write PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 mos, 30 d
(e) Length of stay in Baltimore (yrs., mos., or days) 1 yr 5 Days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Harford
(c) City or town Bel Air
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME David Noel Sullivan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 25, 1944

8. AGE: Years	Months	Days	If less than one day
1		8	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Paul D. Sullivan
13. Birthplace Baltimore

MOTHER
14. Maiden Name Isabel Dilworth
15. Birthplace Baltimore

16 (a) Informant Paul D. Sullivan
(b) Address Bel Air Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 4 1946 (month) (day) (year)
(c) Cemetery or crematory St. Francis
Location Abingdon Md

18 (a) Funeral director Howard E. McCormas
(b) Address Abingdon Md

JAN 3 1946 (a) Date rec'd by local registrar Huntington Williams, Registrar

MEDICAL CERTIFICATION 46

20. DATE OF DEATH Jan 2 1946, at 2:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19.

Immediate cause of death	Duration
Cardiac failure	6 days
Due to Congenital heart disease	1 yr
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Mary Raymond Strader M. D.
Address Union Memorial Hospital Date signed 1-2-46

VS 150

X

G35880

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

/31B

Registered No. G35880

Please write plainly, with unfading ink. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 226 S. WOLFE ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 226 S. WOLFE ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANK G. ZEILER

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. NONE

4. Sex: MALE

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: ANNA ZEILER

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 19 1879

8. AGE: Years 66 | Months 5 | Days 11 | If less than one day: hr. min.

9. Birthplace BALTIMORE MD. (Town, county, and state)

10. Usual Occupation CHAUEFFER

11. Industry or business FOR SELF LIVERY

FATHER
12. Name JOHN S. ZEILER
13. Birthplace GERMANY

MOTHER
14. Maiden Name CATHERINE DEITZEL
15. Birthplace BALTO. MD.

16 (a) Informant ANNA ZEILER (WIFE)
(b) Address 226 S. WOLFE ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JAN. 3/46 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem.
Location

18 (a) Funeral director Leilly & Zeiler Inc.
(b) Address 403 S. WOLFE ST.

JAN - 3 1946 (Date received by Registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH dec. 30 1945, at 10/30 AM.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 10 1945, to Dec 30 1945, and that I last saw h[illegible] alive on Dec 29 1945.

Immediate cause of death

	Duration
Renal Colic	1 day
Renal Calculi	3 yrs
Due to Chronic Nephritis	2 yrs
Chronic Hypertension with Coronary Occlusion & Ulcer	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Geo. D. Lafata M. D.

Address 431 N. Patterson Park Date signed 12/31/45

X

635881

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered No. 635881 (via)

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. USE INK. WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 9 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 415 W. 26th. St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Edward Pollard

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/26/1945

8. AGE: Years	Months	Days	If less than one day
	9	1	hr. min.

9. Birthplace Butler, Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Butler Pollard

13. Birthplace Virginia

MOTHER 14. Maiden Name Elsie Shaw

15. Birthplace Penna.

16 (a) Informant hospital records

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location Johns Hopkins Hospital

18 (a) Funeral directors Johns Hopkins Medical School JAN 3 1946

(b) Address Commissioner of Health

JAN 3 1946 (b) [illegible] Thurlington for Williamsport

(a) Date filed by registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 27 1945, at 2 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 25 1945 to Dec. 27 1945 and that I last saw him alive on Dec. 27 1945

Immediate cause of death resp. failure — Duration

Due to acidosis

Due to pneumonia

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Mary Raymond Shelton M. D.

Address Union Memorial Hosp Date signed 1-27-45

VS 150

3184

X

635882

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 635882

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2440 Druid Hill Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2440 Druid Hill Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leo Cottman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 60 | Months | Days | If less than one day hr. min.

9. Birthplace
(Town, county, and state)

10. Usual Occupation

11. Industry or business

MOTHER | FATHER
12. Name
13. Birthplace
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School DEC 26 1945 Commissioner of Health

18 (a) Funeral director
(b) Address

19 JAN 3 1946 (Date rec'd by registrar) (c) Hunter-Jon Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 18 Dec 1945, at 7:30 P M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William J Holbrook M.D.
Medical Examiner.
Date signed 19 Dec 45

VS 131

0171

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. The information must be carefully supplied. The

635883

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 23

635883 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp. 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. [illegible]
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fred Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School DEC 26 1945
Commissioner of Health

18 (a) Funeral director
(b) Address

19 (a) JAN 3 1946 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 15 1945, at 2 PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Laceration of Intestines

Due to Mesenteric Thrombosis

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Dec 15 1945

VS 151

3169

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. The

GB5884

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G35884

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: The Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Dundalk (If outside city or town limits, write RURAL and give town)
(d) Street No. 100 Ship Way (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rowell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 16, 1945

8. AGE: Years | Months | Days: 1 | If less than one day: hr. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name: Arthur Rowell
13. Birthplace: Massachusetts

MOTHER
14. Maiden Name: Betty Lyon
15. Birthplace: Maryland

16 (a) Informant: Hospital Records
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location University Medical School DEC 27 1945

18 (a) Funeral director: Commissioner of Health
(b) Address

19 JAN 3 1945 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 17 1945, at 6:55A M

21. I certify that death occurred on the date above stated; that I attended deceased from December 16 1945, to December 17 1945, and that I last saw him alive on December 17 1945.

Immediate cause of death: Prematurity
? atelectasis
? congenital defect leftlung

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Gilbert J. Vosburgh M. D.
Address John Hopkins Hosp. Date signed 12-19-45

VS 150

C173

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

535885

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 169

Registered No. 535885

PRINT WITH PENCIL, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway and Fairmount
(c) Hospital or institution: Church Home Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 17 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 102 Roland Heights Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Lawrence Palmer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 21, 1945

8. AGE: Years	Months	Days	If less than one day
		1	17 hrs. min.

9. Birthplace Church Home Hospital
(Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name James A. Palmer
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Lillian Taylor
15. Birthplace Baltimore, Md.

16 (a) Informant Lillian Taylor
(b) Address Baltimore, Md.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location University Medical School DEC 27 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 JAN 3 1946 Houston for Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 22, 1945 at 4:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from December 21, 1945 to December 22, 1945 and that I last saw h. alive on December 22, 1945

Immediate cause of death	Duration
Respiratory Failure associated with	
Due to Prematurity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Bilateral atelectasis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address Church Home & Hosp. Date signed 12-23-45

VS 150

F 5172

G35886

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157c

Registered No. G35886

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: W. B. D. H.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balt
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3935 W. Mulberry St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Sturdevant

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/25/45

8. AGE: Years	Months	Days	If less than one day
			hr. 40 min.

9. Birthplace W. B. Hosp. Hagerstown, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Calvin Edward Sturdevant
13. Birthplace Hagerstown, Md

MOTHER
14. Maiden Name Ethel Mary Gunther
15. Birthplace Balt Md.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location University Medical School DEC 28 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) JAN 3 1946 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 25 1945, at 1 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 25 1945 to Dec 25 1945, and that I last saw her alive on Dec 25 1945

Immediate cause of death	Duration
(1) Anencephalus	
Meningocele.	
(2) Hydrocephalus	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. Schofield
Address West Balt. John Hopk. Date signed 12/26

VS 150

8170 X

G35887 BALTIMORE CITY HEALTH DEPARTMENT X V G35887

CERTIFICATE OF DEATH 1700 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 18 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Harford
(c) City or town Pylesville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert P. Watkins

3 (b) If veteran, name war	3 (c) Social Security Account No.
W.W. # 2	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	SINGLE

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DEC. 29 1924

8. AGE: Years	Months	Days	If less than one day
21	0	3	hr. min.

9. Birthplace PYLESVILLE MD.
(Town, county, and state)
10. Usual Occupation SOLDIER
11. Industry or business US ARMY

FATHER
12. Name EDMUND J. WATKINS
13. Birthplace HARFORD CO. MD.

MOTHER
14. Maiden Name OLETA BUSH
15. Birthplace HARFORD CO. MD.

16 (a) Informant WILLIAM WATKINS (BROTHER
(b) Address PYLESVILLE MD.

17 (a) BURIAL (b) Date thereof JAN. 6/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory NORTH BEND CEM.
Location PYLESVILLE MD.

18 (a) Funeral director Leilby & Seiler Inc.
(b) Address 403 S. WOLFE ST.

19 (a) (b)
(Date rec'd by registrar) Registrar

JAN - 3 1946
VS Rev

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-1- 1946, at 6 15 P. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fractured skull - brain

Due to

Other Conditions Fractured ribs, ruptured liver, lacerations, contusions, & bruised brain.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-1-46 at Baltr. Co. 4 A. M.
(b) Where did injury occur? ¼ mile, east of Harford Co. line.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Collision with a parked automobile

23. Signature Howard J. Mackey M.D.
Medical Examiner.
Date signed 1-2-46

0 X

G35888 ✓ G35888

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRESS WHITE FIRMLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 507 Bloom St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 507 Bloom St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Carroll

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Samuel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 4 1875

8. AGE: Years 70 | Months 6 | Days 30 | If less than one day hr. min.

9. Birthplace Nash, N.C. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Alexander Hunt
13. Birthplace Va

MOTHER 14. Maiden Name Hannah Beckwith
15. Birthplace Va

16 (a) Informant Samuel E. Carroll
(b) Address 507 Bloom St.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Jan. 3, 1945 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Mrs. Lee H. Holland
(b) Address 1631 Druid Hill Ave

19 (a) (Date rec'd by registrar) (b) for Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-31 1944, at 7 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1944 to 12-31 1944, and that I last saw her alive on 12-31 1944.

Immediate cause of death	Duration
Hypertension	
Cerebral Vascular Renal	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. B. Sutler M. D.
Address 2033 S. Dallas Date signed 1/3/45

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35889

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. G35889

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: Provident Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 days
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1535 Penna Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mamie White

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25, 1891

8. AGE: Years 54 | Months 0 | Days 4 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Ethel Williams
(b) Address 1535 Penna. Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 3 1946 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. Lucy A. Holland
(b) Address 1631 Pennsylvania Ave.

19 (a) (Date rec'd by Registrar) (b) Registrar

JAN 5 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-29 1945, at 11:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-25 1945 to 12-29 1945, and that I last saw h.er alive on 12-29 1945.

Immediate cause of death: Congestive Heart failure — Duration: one month

Due to: Essential Hypertension — Duration: undetermined

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George McDonald

Address 844 N. Carey St. Date signed 1/3/46

Investigator for Williams Registrar

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

AB-97904 G35890

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12days
(e) Length of stay in Baltimore (yrs., mos., or days) 1 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 435 Druid Hill Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fannie Adams

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Married

6 (b) Name of husband or wife Jack
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 30-1923

8. AGE: Years	Months	Days	If less than one day
22	11	1	hr. min.

9. Birthplace S.C.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Fuester
13. Birthplace S.C.

MOTHER
14. Maiden Name Nannie Bail
15. Birthplace S.C.

16 (a) Informant Baltimore City Hospitals (Record
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof Jan. 4 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Family Lot
Location Rock Hill N. C.

18 (a) Funeral director Chas. Lee A. Ofuland
(b) Address 1691 Druid Hill Ave.

19 (a) JAN 3 1946 (b) Filed for Registry
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 31- 1945 at 2.05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-19 1945 to 12-31 1945 and that I last saw her alive on 12-31 1945

Immediate cause of death	Duration
Pulmonary TB	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jonathan Howland M. D.
Address 13 Ct. Date signed 1/2/46

635891

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

635891 Registered No. 1310

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1047 N. Fanrale St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 44yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1047 N. Fanrale St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William L. Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Francis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 27, 187

8. AGE: Years 67 | Months 6 | Days 4 | If less than one day hr. min.

9. Birthplace Looney Ck. Va (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Peter Jones
13. Birthplace Va

MOTHER
14. Maiden Name Peggy Blackwell
15. Birthplace Va

16 (a) Informant Hattie Brown
(b) Address 119 Key Road - Portsmouth

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Jan. 3 1946 (month) (day) (year)
(c) Cemetery or crematory Cybutus Mem. Pk.
Location Baltimore, Md.

18 (a) Funeral director Wm. H. Steele
(b) Address 1631 Druid Hill Ave.

19 (a) JAN -3 1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-1- 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-15-1945 to 1-1- 1946, and that I last saw h[illegible] alive on 1-1- 1946

Immediate cause of death:
Hypertension Cardio-Vascular Renal disease — Due to Uremia Coma — Duration 1 yr

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature]
Address 600 Hamburg St. Date signed 1/3/46

THESE WILL PLEASE, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G35898

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

G35898 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1707 Madison Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1707 Madison Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clara C. Barber (Barbour)

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Widow

6 (b) Name of husband or wife Thomas
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 16, 1882

8. AGE: Years	Months	Days	If less than one day
63	1	15	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER	12. Name Owen Morris
	13. Birthplace Va
MOTHER	14. Maiden Name Mildred Lightfoot
	15. Birthplace Va

16 (a) Informant Mrs. Mary Johnson
(b) Address 510 Columbia Rd. N.W.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-4-1946 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Baltimore, Md.
18 (a) Funeral director Wm. Carl H. Stuhlmann
(b) Address 2400 Druid Hill Ave.
19 (a) (Date rec'd by registrar) (b) Huntington Maryland
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-1- 1946, at 1A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-20 1945, to 1-1- 1946, and that I last saw h[illegible] alive on 12-29-1945.

Immediate cause of death	Duration
Chronic Cardiovascular Renal Disease, Arteriosclerosis	
Due to Hemorrhage Cerebral Accident	1 year
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature M. Barber
Address Washington Date signed 1-2-46

VS 150

G35893

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G35893 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1140 Duran St.
(c) Hospital or institution: 1140
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1140 Duran St
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Nora Laura Dixon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	Negro	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/17/1907

8. AGE: Years	Months	Days	If less than one day
38	2	13	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Geo. Dixon
13. Birthplace Calvert County, Md.

MOTHER
14. Maiden Name Laura Dixon
15. Birthplace Prince Island Md.

16 (a) Informant Dorothy Dixon
(b) Address 1032 Druid Hill Ave.

17 (a) Burial (b) Date thereof 1-4-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location West Point Md

18 (a) Funeral director Charles R. Law
(b) Address 802 Madison Ave

19 (a) JAN 3 1946
Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/30 1945 at 11P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-4 1945, to 12/30 1945, and that I last saw h— alive on 12/29 1945.

Immediate cause of death Chronic Myocarditis
Hypertension

Duration
4 Mo
16 Da

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature B. J. Hatcher M. D.
Address 1725 Pulton Date signed 1/3/46

Hunting for Relatives

X

TYPE OR WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35894

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94 2

G35894 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1028 Aisquith St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1028 Aisquith St
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Glenn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Elizabeth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 11, 1885

8. AGE: Years 60 | Months 8 | Days 20 | If less than one day hr. min.

9. Birthplace S. Carolina
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Bethlehem Steel Co.

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Eugene Glenn
(b) Address 1429 W. Lanvale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 3/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location A A County Md.

18 (a) Funeral director Mrs. Lottie A. Elliott
(b) Address 1129 N. Caroline St.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

JAN – 3 1946

Huntington Hollingsworth

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 31 1945, at 3:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 8 1945 to Dec 31 1945 and that I last saw h[illegible] alive on Dec 31 1945.

Immediate cause of death	Duration
(a) Coronary Thrombosis	1 hr
Due to (b) Gastro Enteritis	2 days
Due to (c)	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D. J. Halpin

Address [illegible] Date signed Jan 2 1946

X

635895

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

635895
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2312 Herkheimer St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2312 Herkheimer
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Josephine M Hosky
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widow

6 (b) Name of husband or wife Edward Hosky
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/2/1888

8. AGE: Years	Months	Days	If less than one day
57	10	29	hr. min.

9. Birthplace Balto
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William Clark
13. Birthplace Balto Md

MOTHER
14. Maiden Name Robinson
15. Birthplace S C

16 (a) Informant Dorothy Colton
(b) Address 2312 Herkheimer St

17 (a) Burial (b) Date thereof 11/7/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd

18 (a) Funeral director Edward Foreman
(b) Address 2359 Forest Blvd

19 (a) Date received JAN 9 1946 (b) Harrington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/1 1946, at 2:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/29 1945 to 1/1 1946 and that I last saw him alive on 1/1 1946.

Immediate cause of death
Cerebral Hemorrhage
Pulmonary Edema
Due to Hypertensive Heart Disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration
3 days

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leonard Wellenstein M. D.
Address 5 Dyer W 31 Date signed 1/2/46

G35896 S-38125 G35896

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

161 a

Registered No.....

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1019 Ensor St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ....yrs....mos....ds. How long in U. S. If of foreign birth?....yrs....mos....ds.

2. FULL NAME Baby Boy Powell

If U. S. Veteran, specify WAR .....

(a) Residence: No. 1019 Ensor St., ...Ward.

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
M	C	Baby

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, year) 12-17-45

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
				4 hrs.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) 1019 Ensor
(State or country)

FATHER

13. NAME Not Known

14. BIRTHPLACE (city or town)
(State or country)

MOTHER

15. MAIDEN NAME Lutecia Powell

16. BIRTHPLACE (city or town) Churchfield
(State or country) W. Va.

17. INFORMANT Ethel Powell

(Address) 1019 Ensor St.

18. BURIAL, CREMATION, OR REMOVAL

Place JOHNS HOPKINS MEDICAL SCHOOL Date DEC 27 1945

19. UNDERTAKER Commissioner of Health

(Address)

20. JAN 3 1946 Huntington Williams M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) 12-17-45

22. I HEREBY CERTIFY, That I attended deceased from ....., 19...., to ....., 19....

I last saw h.... alive on ....., 19.... Death is said to have occurred on the date stated above, at ....m.

The principal cause of death and related causes of importance were as follows:

Asphyxia-d
Prolapsus - funis
Child dead
after birth

Date of onset

Other conditions contributing to death but not related to principal cause

Was an operation performed? ..... Date of .....

For what disease or injury? .....

Name of operation .....

What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ....., 19....

Where did injury occur? .....
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place .....

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased?

If so, how? .....

(Signed) G. Wealther M. D.

(Address) 1443 Eager St.

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Please Call For body — 3176 X

635897

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 635897

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
U.S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) 17 days

2. USUAL RESIDENCE OF DECEASED:
(a) State NY (b) County
(c) City or town New York
(If outside city or town limits, write RURAL and give town)
(d) Street No. 37 Oliver St.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME
Hassan, Ali

3 (b) If veteran, name war

3 (c) Social Security Account No. 086-14-2203

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 15, 1891

8. AGE: Years	Months	Days	If less than one day
54	9	14	hr. min.

9. Birthplace Turkey
(Town, county, and state)
10. Usual Occupation fireman
11. Industry or business seafarer

FATHER
12. Name Ali Hassan
13. Birthplace Turkey

MOTHER
14. Maiden Name Amenia
15. Birthplace Turkey

16 (a) Informant Records
(b) Address US Marine Hospital, Balto, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 3 1946 (month) (day) (year)
(c) Cemetery or crematory Greene & Mahoney Funeral Home
Location 5800 York Rd. Md.
18 (a) Funeral director ODER FUNERAL HOME INC.
(b) Address 4644 York Rd.
19 (a) JAN - 3 1946 (b) Huntington Williamsport, Md.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 29 1945, at 11:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 12 1945 to Dec. 29 1945, and that I last saw him alive on Dec. 29 1945.

Immediate cause of death Hodgkin's disease, liver, spleen, abdominal and pelvic nodes — Duration UNKNOWN

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Wilson
John L. Wilson, Lt. Surgeon
Address Clinical Director Date signed 1/2/46

VS 190

G35898

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

521

G35898

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 706 S Sharp

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 706 S Sharp St
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ira Thompson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/7/1882

8. AGE: Years 63 | Months 6 | Days 26 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John W. Thompson
13. Birthplace Md

MOTHER
14. Maiden Name Annie Redding
15. Birthplace Del

16 (a) Informant Cora Rawlings

(b) Address 112 W Wilkens Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-3-47 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location Balto City

18 (a) Funeral director Isaiah L. Brown & Son

(b) Address 104 W Monument St

JAN 3 1946

(Local registrar) (b) by Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/31/45 19 ____ at ____ M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 10 19 45 to Dec 31 19 45
and that I last saw h alive on Dec 31 19 45

Immediate cause of death

Valvular Heart disease

Duration: 6 months

Due to

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Lincoln Shelton M.D.

Address 706 S. Sharp St Date signed 1/3/46

G35899 BALTIMORE CITY HEALTH DEPARTMENT G35899
CERTIFICATE OF DEATH 33a
Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1209 Upton St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State ..... (b) County .....
(c) City or town Baltimore Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1209 Upton St. (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Sarah Catherine Gross.
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Fem. | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Widowed
6 (b) Name of husband or wife Solan Gross
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) June 4 1865
8. AGE: Years 80 | Months 8 6 | Days 27 | If less than one day ..... hr. ..... min.
9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Edward Gross
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Greta Spence
15. Birthplace Yorktown

16 (a) Informant Gladys Edwards
(b) Address 1209 Upton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/3/45 (month) (day) (year)
(c) Cemetery or crematory Arlington Mem. Park
Location Balto Co.

18 (a) Funeral director Isaiah L. Brown & Son
(b) Address 108 W Montgomery St

19 (a) [illegible] (b) [illegible] Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/31/1945 at 7:20 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1 1945 to Dec. 31 1945, and that I last saw h alive on Dec. 30 1945

Immediate cause of death	Duration
Acute Bronchopneumonia	10 days
Due to Influenza	21 days
Due to	
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? ..... (Specify type of place)
(e) Means of injury .....
23. Signature Huntington Williams M. D.
Address 908 S. Chapel Date signed 1/4/46

VS 150

G35900

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

6

Registered No. G35900

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

26

(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6214 Terrace Way.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME William Ritchauer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male.	White	

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-16-44

8. AGE: Years	Months	Days	If less than one day
	3	15	....hr. ....min.

9. Birthplace Pa.
(Town, county, and state)

10. Usual Occupation.....
11. Industry or business

FATHER
12. Name Frank Ritchauer
13. Birthplace Pa.

MOTHER
14. Maiden Name Bertha Peters
15. Birthplace Pa.

16 (a) Informant Friends.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (b) Date thereof 1/1/46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory.....
Location Slatington, Penna.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address North & Penna. Aves,

19 (a) JAN - 3 1946 (b) Huntington Williams M.D.
rec'd reg. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan- 1 1946 at 6.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan- 1 1946 to Jan- 1 1946 and that I last saw him alive on Jan 1 1946

Immediate cause of death	Duration
Adrenal Insufficiency	7 hrs.
Due to Meningococcemia	1 day
Due to.....	
Other Conditions Meningitis	1 day

(Include pregnancy within 3 months of death)

Date of operation.....
Major findings of operation:.....
of autopsy: Bilat. adrenal hemorrhage

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....
23. Signature Walter M. Tasen M. D.
Address J. H. H. Date signed 1-6-46

X TASem

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35901

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

117a

G35901 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: South Balto. General Hospt.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 15

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1301 Clark Court -25-
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Laurence H. Irvin

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-10-9425

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mabel Irvin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 22-1910

8. AGE: Years 35 | Months -7 | Days - | If less than one day hr. min.

9. Birthplace Joliet, Ill.
(Town, county, and state)

10. Usual Occupation Painter

11. Industry or business Construction Service Inc

FATHER 12. Name George Irvin
13. Birthplace Virginia

MOTHER 14. Maiden Name Clara Dampson
15. Birthplace Kentuckey

16 (a) Informant Myrtle Koenig
(b) Address 21 Bristol Ave

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 1 2 46 (month) (day) (year)

(c) Cemetery or crematory Glen Haven Cemetery
Location Glenburnie, Md

18 (a) Funeral director Milton Stallings Funeral Home
(b) Address 3914 Hanover St

19 (a) (Date received by registrar) (b) Registrar

JAN -3 1946

VS 150

MEDICAL CERTIFICATION 46

20. DATE OF DEATH 1 2 1945, at 9 30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12 25 1945 to 1 2 1946, and that I last saw h. alive on 1 2 1946.

Immediate cause of death
Peritonitis
Due to Rupture of gastric ulcer

Due to

Other Conditions Lung abscess
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
6 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thos E Wheeler M. D.
Address 1 Court Square Date signed 1/2/46

G35902

CMK-97851

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 116

G35902

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 75- 6- 14

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1255 E. Biddle Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Carroll

3 (b) If veteran, name war.

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Wm C. Dougherty
6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) June 16-1870

8. AGE: Years	Months	Days	If less than one day
75	6	14	hr. min.

9. Birthplace Maryland (town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name George Carroll
13. Birthplace Maryland

MOTHER
14. Maiden Name Charlotte Kitter
15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/3/45 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location E. North Ave.

18 (a) Funeral director George J. Roth Inc
(b) Address 1735 Bedford Ave.

19 (a) (Date rec'd by registrar) (b)

JAN -3 1946

Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH December 30 1945, at 6:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 15 1945, to Dec. 30 1945, and that I last saw h im alive on Dec. 30 1945.

Immediate cause of death	Duration
Bronchopneumonia	
Due to	
Due to	
Other Conditions	

Dilated esophagus
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: none
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature T. P. Jerrigan M. D.
Address Baltimore City Hosp Date signed 1-2-45

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

635903

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

635903 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline Street
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 8 yrs
(e) Length of stay in Baltimore (yrs., mos., or days): life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimcre
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1113 N. Patterson Park Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Robert C. Carroll

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Marie Anna (nee Kokta)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 13, 1906

8. AGE: Years	Months	Days	If less than one day
39 yrs.	1	18	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business General Baking Company

FATHER
12. Name Albert Carroll
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs. Marie A. Carroll - wife
(b) Address 1113 N. Patterson Park Ave.

17 (a) Burial (b) Date thereof 1/4/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street

19 (a) JAN - 3 1946 Registrar
(Signature of Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-1 1946 at 2:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-26 1945 to 1-1 1946 and that I last saw him alive on 12-31 1945.

Immediate cause of death	Duration
Respiratory failure.	
Due to Uremia.	
Due to Chronic Nephritis Hypertension & Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm F. Franke M. D.
Address 10 W. Lanvale St. Date signed 1-2-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35904

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 A

G35904 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 500 N. Kenwood Avenue
(c) Hospital or institution:

7

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 62 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 500 N. Kenwood Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** EMIL LUNAK

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of ~~husband~~ or wife Mary (nee Janecek)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 22 1869

8. AGE: Years	Months	Days	If less than one day
76 yrs.	1	9	hr. min.

9. Birthplace Czechoslovakia
(Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business H.J. Kohler & Son

FATHER
12. Name unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs. Emil Lunak - wife
(b) Address 500 N. Kenwood Avenue

17 (a) Burial (b) Date thereof 1/4/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or ~~crematory~~ Oak Hill
Location Horner's Lane, Balto. Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street

19 (a) JAN - 3 1946 (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH December 31 1945, at 8:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 5 1945 to Dec 31 1945, and that I last saw him alive on Dec 31 1945

Immediate cause of death Hypostatic Pneumonia — Duration 12/29/45

Due to Carcinoma of Pancreas

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William J. Roarer M. D.
Address 801 E Kenwood Ave Date signed 1/3/46

X

635905

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95 (1) Registered No. 635905

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 806 CLOVER RD
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-1-8
(e) Length of stay in Baltimore (yrs., mos., or days) 2 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTO
(If outside city or town limits, write RURAL and give town)
(d) Street No. 806 CLOVER RD
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH FLEISCHER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6 (b) Name of husband or wife ROSE
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years	Months	Days	If less than one day
69			hr. min.

9. Birthplace AUSTRIA
(Town, county, and state)
10. Usual Occupation NONE
11. Industry or business

FATHER 12. Name	NOT KNOWN
FATHER 13. Birthplace	AUSTRIA
MOTHER 14. Maiden Name	NOT KNOWN
MOTHER 15. Birthplace	AUSTRIA

16 (a) Informant WIFE
(b) Address

17 (a) BURIAL (b) Date thereof 1-3-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory SHOMREI TFILOH
Location WINDSOR MILL RD

18 (a) Funeral director JACK LEWIS INC
(b) Address 2100 EUTAW PLACE

19 (a) (Date received by Registrar) JAN-3 1946 (b)

Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-2-1946, at 6 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1941, to 1-2 1946, and that I last saw h alive on 1-2 1946.

Immediate cause of death	Duration
Cerebral Hemorrhage	2 months
Due to Hypertension	
Cardiac Hypertrophy	10 years
Due to	
Other Conditions General arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Gustave Cooper M. D.
Address 2201 Eutaw Place Date signed 1/3/46

X

G35906

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G35906 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St. Rutland Ave
(c) Hospital or institution: Sinai

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4 N. Broadway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sadie Blatt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife 1587
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
58			hr. min.

9. Birthplace Russia
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name —
13. Birthplace Russia

MOTHER
14. Maiden Name —
15. Birthplace Russia

16 (a) Informant Hosp Records
(b) Address

17 (a) Burial (b) Date thereof 1-3-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Chev Shalom
Location

18 (a) Funeral director Jack Levine Inc
(b) Address 1439 E. Baltimore St

19 (a) JAN 3 1946 Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 29 Dec. 1945, at 10:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 24 1945, to Dec. 29 1945, and that I last saw h[illegible] alive on Dec. 29 1945.

Immediate cause of death	Duration
Pneumonia	?
Due to	
Due to	
Other Conditions Hypertensive Heart dis. Uremia	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Bernard Burgin M. D.
Address Sinai Hosp. Date signed Jan. 2 1946

Huntington Williams, M.D.

109

G35907

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

132

Registered No. G35907

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1420 Ward Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1420 Ward St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country No

3 (a) FULL NAME Charles W. Mallock

3 (b) If veteran, name war W.W. #1

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-6-1895

8. AGE: Years 50 | Months 11 | Days 21 | If less than one day hr. min.

9. Birthplace Balto. Md.
(town, county, and state)

10. Usual Occupation Laborer.

11. Industry or business

FATHER
12. Name Wm. H. Mallock.
13. Birthplace Eastern Shore, Md.

MOTHER
14. Maiden Name Eliza Mill
15. Birthplace Md.

16 (a) Informant Louis Mallock (Bro)
(b) Address 1239 Bayard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/3/46 (month) (day) (year)

(c) Cemetery or crematory Balto Natl Cem.
Location Balto. Md.

18 (a) Funeral director Chas. Hooper
(b) Address 512 N. Carrollton Ave.

JAN - 3 1946
(Date rec'd by registrar)

Huntington Williams, M.D.
Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 27 1945 at 9:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Tuberculous caseous pneumonia
Due to Tuberculosis
Other Conditions Arteriosclerosis, moderate
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Stavitsky M.D.
Medical Examiner.
Date signed 12-28-45

X

Instructions: Please write the causes of death clearly and legibly. The coverage is especially important. Physicians: please write...

635908 | BALTIMORE CITY HEALTH DEPARTMENT | 635905

CERTIFICATE OF DEATH

8 3a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1715 Caplan Road
(c) Hospital or institution:
1516
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 16 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1715 Caplan Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jennie L. Evans

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife James S. Evans
6 (c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) Nov 7-1885

8. AGE: Years 60 | Months 1 | Days 21 | If less than one day hr. min.

9. Birthplace Barnwell South Carolina (Town, county, and state)

10. Usual Occupation Homemaker

11. Industry or business

FATHER
12. Name Wm H. Key
13. Birthplace South Carolina

MOTHER
14. Maiden Name Ipsie Bennett
15. Birthplace South Carolina

16 (a) Informant James B Evans
(b) Address 1715 Caplan Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/3/46 (month) (day) (year)
(c) Cemetery or crematory St. Helena
Location Beaufort South Carolina

18 (a) Funeral director J. B. Hilliard Son
(b) Address 300 Eutaw Place

19 (a) Date received by registrar JAN 3 1946 (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 1 1946 at 2:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 19, 1945 to Jan. 1, 1946, and that I last saw h alive on Jan. 1, 1945

Immediate cause of death Cerebral hemorrhage — Duration 2 days
Due to High blood pressure — 5 years
Due to
Other Conditions Congestive heart failure — 13 days.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Gilbert E. Rudman M. D.
Address 2517 W. Balto. St. Date signed Jan 2 1946

X

G35909

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46D ✓

G35909 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 450 E. 22nd St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12-24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 450 E. 22nd St.
(If rural give location)
(e) Citizen of foreign country? ✓ (Yes or No)
If yes, name country

3 (a) FULL NAME CARRIE LAVINIA HORN

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 17, 1873

8. AGE: Years	Months	Days	If less than one day
72	3	14	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name George M. Horn
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Carrie Kelly
15. Birthplace Balto., Md.

16 (a) Informant Miss M. Alice Horn
(b) Address 450 E. 22nd St.

17 (a) Cremation (b) Date thereof 1/3/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JAN - 3 1946 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 1, 1946, at 6:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 19 Jan 19 45 to Jan 1 19 46
and that I last saw h[illegible] alive on Dec 31 19 45

Immediate cause of death Intestinal obst

Due to Carcinoma of rectum

Due to

Other Conditions Pulm. Embolism

(Include pregnancy within 3 months of death)

Date of operation 12-24-45

Major findings of operation: Colostomy

of autopsy: ✓

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ✓
(b) Date of occurrence ✓ at M
(c) Where did injury occur? ✓
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ✓ While at work? ✓
(Specify type of place)
(e) Means of injury ✓

23. Signature Chas F Blake M. D.
Address 20 E Preston Date signed 1/3/46

X

G35910

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

931

Registered No. G35910

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison + Linden
(c) Hospital or institution: Maryland General 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2109 Maryland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William B. Hardin

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 24, 1881

8. AGE: Years	Months	Days	If less than one day
64		8	hr. min.

9. Birthplace Easton, Md.
(Town, county, and state)
10. Usual Occupation Salesman & Clerk
11. Industry or business R. C. Hardin Co.

FATHER 12. Name Charles Hardin
15. Birthplace Easton, Md.

MOTHER 14. Maiden Name Elizabeth Pastorfield
15. Birthplace Trappe, Md.

16 (a) Informant Mr. Purcell Hardin
(b) Address 3922 Maine Ave.

17 (a) Burial (b) Date thereof 1/5/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Spring Hill Cem.
Location Easton, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JAN - 3 1946 (b) Huntington for Williams M.D.
(Date rec'd by registrar) (Signature of registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/2 1946, at 7:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/19 1945 to 1/2 1946, and that I last saw him alive on 1/1 1946.

Immediate cause of death	Duration
Coronary Thrombosis	
Due to Arteriosclerotic C.V. Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Martin E. Stoutsel M. D.
Address Md. Genl. Hospital Date signed 1/2/46

G35911

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 65B

G35911
Registered No.

Please write the causes of death clearly and legibly. Physicians: please write as carefully and legibly as possible. The correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1157 Ward St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph V. Grube

3 (b) If veteran, name war: none

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 6, 1928

8. AGE: Years	Months	Days	If less than one day
17	1	25	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Harrison C. Grube
13. Birthplace Va.

MOTHER
14. Maiden Name Carrie Uttenreiter
15. Birthplace Balto., Md.

16 (a) Informant Mr. H. C. Gruba
(b) Address 1157 Ward St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/5/46 (month) (day) (year)
(c) Cemetery or crematory St. Matthews Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

JAN - 3 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 1 1946 at 11:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CUASE OF DEATH Pneumonia, Bilateral

Due to Adrenal Hemorrhage

Due to Septicaemia

Other Conditions Congestion of all Viscera
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skotarelis M.D.
Medical Examiner.
Date signed 1-2-46

VS 151

G35912

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

G35912
Registered No.

Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 123 N Schroeder St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 123 N Schroeder St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Josephine Allen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F. | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years unknown | Months | Days | If less than one day about 7 0 + hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name unknown
13. Birthplace

MOTHER 14. Maiden Name unknown
15. Birthplace

16 (a) Informant Geneva Wright
(b) Address 123 N Schroeder St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-4-46 (Month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cemetery
Location Md.

18 (a) Funeral director Scholastus Halstead
(b) Address 1918 Druid Hill Ave

19 JAN - 3 1946 (Date received by Registrar) (b) Waiting for Williams M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 30 19 45 at 8:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/22 1945 to 12/30 1945 and that I last saw her alive on 12/22 1945

Immediate cause of death Generalized Arteriosclerosis

Due to Senility

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. Walter Sherwood M. D.
Address 201 N Carey St. Date signed 1/3/46

G25913

37647 med Exam Case

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Reg. No. G25913

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 641 N. Central Ave (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Alice Matthews

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	black	married

6 (b) Name of husband or wife.....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 6-15-08

8. AGE: Years	Months	Days	If less than one day
37	6	15	..... hr. ..... min.

9. Birthplace Md (Town, county and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Wesley Peackle
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Anne?
15. Birthplace Md.

16 (a) Informant Joseph Matthews
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-2-46 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location.....

18 (a) Funeral director Adolphus Halsted
(b) Address 918 Druid Hill Ave

19 JAN 3 1946 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 30 1945, at 1 6-3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-25- 1946 to 12-30- 1945, and that I last saw her alive on 12-30- 1946

Immediate cause of death	Duration
cardiac & renal failure	
Due to Burns, 2nd and 3rd	
Due to degree, severe	5d.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident S/I
(b) Date of occurrence 25 Dec 45 at 1 P M
(c) Where did injury occur? Balto, Balto Md. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? home While at work? no (Specify type of place)
(e) Means of injury burns, conflagration

23. Signature H. Bauer Huggins M.D.
Address Johns Hopkins Date signed 30 Dec 45

VS 150 For A.C.J. Lubinski, by Howard J. Anderson, M.D. X

635914

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 D

Registered No. 635914

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1013 E. Monument St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5'
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1013 E. Monument St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Candies Gulley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15, 1883

8. AGE: Years	Months	Days	If less than one day
62	7	17	hr. min.

9. Birthplace Raleigh N. Carolina (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Columbus Jones
13. Birthplace N.C

MOTHER
14. Maiden Name Clara Hannah
15. Birthplace N.C.

16 (a) Informant Emma Smith
(b) Address 1015 E Monument St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 3/45 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location A.A. County Md

18 (a) Funeral director Mrs Roberta A. Elliott
(b) Address 1129 N. Caroline St

JAN - 3 1946 Huntington Williams
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 2 1946, at 7 A M

21. I certify that death occurred on the date above stated, that I attended deceased from Nov 1945 to Jan 2 1946, and that I last saw h[illegible] alive on Dec 3 1945

Immediate cause of death	Duration
Myocardial degeneration	
Due to	
Due to Senile changes. Old age.	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. E. Burwell
Address 121 Aliquippa Date signed M. 1-2-46 D.

VS 150

G35915

CWK-97145

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131 a

Registered No. G35915

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Avenue

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 55 days

(e) Length of stay in Baltimore (yrs., mos., or days) 5 Yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1630 Gilmor Street

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Georgia Maye Ockeny

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Separated

6 (b) Name of husband or wife Edward

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1-1879

8. AGE: Years	Months	Days	If less than one day
66	8	0	hr. min.

9. Birthplace Maryland

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Archer Scott

13. Birthplace Maryland

MOTHER

14. Maiden Name Rosa Sedgewick

15. Birthplace Maryland

16 (a) Informant Records-Balto. City Hospitals

(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof Jan 6, 1946

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Sharp St. Cemetery

Location Chase Md

18 (a) Funeral director Mrs. Robert O. Elliott & Dgt.

(b) Address 1129 N. Carolina St.

19 (a) JAN - 9 1946 (b) Huntington Williams M.D.

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 1 19 46 at 2:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 7 19 45 to Jan. 1 19 46

and that I last saw h er alive on Jan. 1 19 46

Immediate cause of death Uremia

Due to Nephrosclerosis

Due to Hypertensive Cardiovascular Disease

Other Conditions

Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: none

of autopsy: as above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature T. P. Jerrigon

Address Baltimore City Hosp. Date signed 1-7-46 M. D.

VS 150

635916

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 D

Registered No. 635916

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2401 Hamilton Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2401 Hamilton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Bertha Trageser

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	widow

6 (b) Name of husband or wife Joseph J. Trageser
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 23, 1875

8. AGE: Years	Months	Days	If less than one day
70	11	8	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation housework
11. Industry or business

FATHER
12. Name John Stuckler
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine ?
15. Birthplace Germany

16 (a) Informant Mrs Evan D. Edwards
(b) Address 2401 Hamilton Ave

17 (a) Burial (b) Date thereof 1-4-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director L. J. Rush
(b) Address 535 Harford Rd

19 (a) JAN - 3 1946 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 31 1945 at 11:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 15 1945 to Dec 31 1945 and that I last saw h[illegible] alive on Dec 30 1945.

Immediate cause of death Myocardial Insufficiency

	Duration
Due to	
Due to	
Other Conditions Arteriosclerosis & Hypertension	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Evan D. Edwards M.D.
Address 1337 S. Chapel Gate signed 1/1/46

VS 150

G35917

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1572

Registered No. G35917

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eutaw & Lee Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1717 Lafayette Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joan Marie Kiel

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 25-1945

8. AGE: Years	Months	Days	If less than one day
	1	8	hr. min.

9. Birthplace Balto Md. (Town, county, and state)
10. Usual Occupation child
11. Industry or business

FATHER
12. Name Gerard Kiel
13. Birthplace Balto.

MOTHER
14. Maiden Name Virginia Davis
15. Birthplace Balto.

16 (a) Informant Mrs. Gerard Kiel
(b) Address 1717 Lafayette Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-4-46 (month) (day) (year)
(c) Cemetery or crematory Woodland
Location Baltimore

18 (a) Funeral director Leonard J. Luck
(b) Address 5305 Harford Road.

19 (a) (Date rec'd by Registrar) (b) Livingston Hill (Registrar)

JAN 3 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/2/46, 19.. at 3:35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/25 1945 to 1/2 1946.
and that I last saw h alive on 1/2 1945
Immediate cause of death Bronc. Pneum.

	Duration
Due to Congenital atelectasis	
Due to Prem. birth.	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Theresa Brown M. D.
Address Univ. Hosp. Date signed 1/2/46

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

635918

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

42D

Registered No. 635918

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 4118 Kingsway (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles C. Cullison

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: M.

6 (b) Name of husband or wife Catherine E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 18-1887

8. AGE: Years 58 | Months 6 | Days 15 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation auto mechanic

11. Industry or business

FATHER 12. Name Henry Cullison

13. Birthplace Md.

MOTHER 14. Maiden Name Elizabeth Filson

15. Birthplace Md.

16 (a) Informant Catherine E. Cullison

(b) Address 4118 Kingsway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-5-46 (month) (day) (year)

(c) Cemetery or crematory Parkwood

Location Balto

18 (a) Funeral director Leonard J. Luck

(b) Address 5306 Harford Rd.

19 JAN - 3 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 2 1946, at 1 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from ____ 19__, to Jan. 2 1946, and that I last saw living on Arrival at Hosp.

Immediate cause of death CARCINOMA of Lung with massive Hemorrhage — Duration ?

Due to resulting from erosion of Blood Vessel

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Russell Yates M. D.

Address Sinai Hosp Date signed 1-2-46

Burial X

VS 150

correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

635919

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 178X

Registered No. 635919

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3108 Belmont Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ernest W. Parks

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-10-7576

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Eliz. R. (Polster)

6 (c) If dive, give age years

7. Birth date of deceased (mo., day, yr.) March 1, 1887

8. AGE: Years 58 | Months 10 | Days - | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Production Mgr

11. Industry or business Arundel Ice Cream Co

FATHER
12. Name Wm. Parks
13. Birthplace Md.

MOTHER
14. Maiden Name Annie E. Lewis
15. Birthplace Md.

16 (a) Informant Mrs. Elizabeth R. Parks
(b) Address 3108 Belmont ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-4-46 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location Balto. Md.

18 (a) Funeral director Harry H. Wright
(b) Address 4101 Edmondson Ave.

19 JAN -3 1946 (Date rec'd by registrar) (b) Huntington Williamson M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH January 1, 1946 at 3 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to Exa death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Edema of Glottis; Acute pulmonary Edema

Due to Exposure to Ammonia

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-1-46 at 2:15 P.M. 20/2
(b) Where did injury occur? 302 N. Smallwood St.
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury Exposure to ammonia fumes

23. Signature Robert Lee Preston M.D.
Medical Examiner.
Date signed Jan 2 1946

VS 151

635920 ✓ 635920

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1700 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 36 min
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1456 Reynolds St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John L. Webster

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1913

8. AGE: Years 32 | Months 6 | Days | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Long Shoreman

11. Industry or business

FATHER 12. Name George Webster

13. Birthplace Md

MOTHER 14. Maiden Name Mary Jones

15. Birthplace Poland

16 (a) Informant Mary Webster

(b) Address 1456 Reynolds St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 5/46 (month) (day) (year)

(c) Cemetery or crematory Holy Cross Cem. Co.

Location Baltimore

18 (a) Funeral director Fred W. Ozarowski

(b) Address 1930 Fountain Ave

19 (a) (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 151 JAN - 3 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 2 1946, at 2 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cardiac Arrest

Compound Comminuted Fracture

Due to Right Leg

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 24/2

(a) Date of injury 1/2/46 at 2:10 A. M.

(b) Where did injury occur? Key Highway & Cross St

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no

(d) Means of injury Auto and fixed object

23. Signature Roland Curtis Gutman M.D. Medical Examiner.

Date signed 1-2-46

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

635921

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 D

635921
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1834 Gough St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1834 Gough St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julianna Zebrowski

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1868

8. AGE: Years 77 | Months | Days | If less than one day hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation House Work

11. Industry or business at Home

FATHER
12. Name Unk.
13. Birthplace Poland

MOTHER
14. Maiden Name Unk.
15. Birthplace Poland

16 (a) Informant Sophie Rydzewski
(b) Address 1834 Gough St.

17 (a) Burial (b) Date thereof Jan 4 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Fred W. Orazewski
(b) Address 1930 Eastern Ave.

19 (a) (b)
(Date rec'd by registrar) Registrar

JAN 3 1946 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 31 1945, at 7 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 30 1945 to Dec 31 1945, and that I last saw her alive on Dec 30 1945

Immediate cause of death Arteriosclerosis C.V. disease — Duration

Due to

Due to

Other Conditions Senility

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. H. Zeller M. D.

Address 3400 E. Balto St. Date signed Jan 3, 1946

INK. Every item of information should be carefully supplied. The Please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians must

G35928

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95 B

Registered No. G35928

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 508 Arlington Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 508 Arlington Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Leroy Muth

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-09-6252

4. Sex M.

5. Color or race W.

6 (a) Single, married, widowed, or divorced Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/23/1903

8. AGE: Years 42 | Months | Days 8 | If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Accountant

11. Industry or business

FATHER
12. Name Wm. S. Muth
13. Birthplace Baltimore

MOTHER
14. Maiden Name Alice T. Burkerson
15. Birthplace Baltimore

16 (a) Informant Mrs Alice Ruggles
(b) Address 1512 Cranks Ave

17 (a) Burial (b) Date thereof 1/3/46.
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet Cem
Location Frederick Ave

18 (a) Funeral director J. D. Tobey Home
(b) Address 1318 Light St.

19 (a) JAN 3 1946 (b) Huntington Williams, M.D.
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 31, 1945, at 5:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 9 1945, to Dec. 31 1945, and that I last saw him alive on Dec. 31 1945.

Immediate cause of death: Rheumatic Heart Disease — Duration: 20 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature C. H. Hayes M. D.
Address 1600 N. Charles St. Date signed 1-2-46

VS 150

G35923

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 3 10

G35923 Registered No.

Every item of information should be carefully supplied. The cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1112 W Lexington St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 d.
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1112 W Lexington St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George William Lewis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Col

6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Ruby Lewis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov-15-76

8. AGE: Years | Months | Days | If less than one day

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name James Lewis
13. Birthplace Va

MOTHER 14. Maiden Name Robinson
15. Birthplace Va

16 (a) Informant Ophia Lewis
(b) Address 1112 W Lexington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 3 46 (month) (day) (year)

(c) Cemetery or crematory Arbutus Memorial
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

JAN - 3 1946 (Date rec'd by Registrar) (b) Huntington Williams Md

PLEASE WRITE PLAINLY, WITH UNFADING INK correct age is especially important. Physicians: please

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-29-1945 at PM M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-20-1945, to 12-29 1945, and that I last saw h alive on 12-29-1945.

Immediate cause of death Chronic Cardiovascular Renal Disease - Hypertension — Duration 6 yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M.D.
Address 600 N Caroline St Date signed 1-7-46

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35924

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G35924

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1105 W. Saratoga St

(c) Hospital or institution: Balto, Md

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No 1105 W. Saratoga St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Harry Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Col

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Alberta Brown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 10, 1877

8. AGE: Years 68 | Months 10 | Days 19 | If less than one day hr. min.

9. Birthplace A. A. Co. Md.

(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Harrison Brown.

13. Birthplace A. A. Co. Md.

MOTHER 14. Maiden Name Jamie Hopkins

15. Birthplace A. A. Co. Md.

16 (a) Informant Alberta Brown.

(b) Address 1105 W. Saratoga

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 3, '46 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location

18 (a) Funeral director Mrs. Katie R. Williams

(b) Address 322 N. Schroeder St

JAN 3 1946

19 (a) (b) Registrar

(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/29 1945 at 8:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/28/45 to 12/29/1945.

and that I last saw h alive on 12/29/1945.

Immediate cause of death Coronary Thrombosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation None

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature [illegible] M.D.

Address 1131 Hollins St Date signed 12/30/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35925

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 87 E

G35925 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 18
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 203 Ellington Ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ula Catherine Hayes (Oxendine)
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	negro	separated Sp

6 (b) Name of husband or wife Junior Hayes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/1/20

8. AGE: Years	Months	Days	If less than one day
25	8	30	hr. min.

9. Birthplace Dillon S. C. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Tom Oxendine
13. Birthplace Dillon S. C.

MOTHER
14. Maiden Name Bessie
15. Birthplace Dillon S C

16 (a) Informant Bessie Oxendine
(b) Address 203 N. Arlington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 4, 1946 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 922 N. Schroeder St.

19 (a) (Entered by) (b) Huntington Williams

JAN 3 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 31 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-31 1945 to 19
and that I last saw h.er alive on 12-31 19 45

Immediate cause of death	Duration
Respiratory failure	
Due to Increased intracranial pressure(?) from convulsions	
Due to ?	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. M. Mace M. D.
Address Univ. Hospital Date signed 12-31-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35926

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G35926 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2819 Bonbert Drive (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) **FULL NAME** Eula Royster

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: C.

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Henry Royster

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 31, 1891

8. AGE: Years 54 | Months 10 | Days 29 | If less than one day hr. min.

9. Birthplace NORTH CAROLINA (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name William Royster
13. Birthplace N.C

MOTHER
14. Maiden Name Rosa Loyster
15. Birthplace North Carolina

16 (a) Informant Norrine Royster
(b) Address 2819 Bonbert Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 4 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location

18 (a) Funeral director Wm. Rafil R. Williams
(b) Address 222 N. Schroeder St.

19 (a) JAN - 3 1946 (Date rec'd by registrar) Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 29 1945, at 9 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 27 1945 to Dec 29 1945, and that I last saw h[illegible] alive on Dec 29 1945

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to	2 days
Hypertensive Cardio Vascular disease	
Other Conditions	2

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. E. Wheeler M. D.
Address South Balto Gen. Hosp Date signed 12/29/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35927

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

G35927 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline St.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 822 Fredenick Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs Rose Ammenhauser

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years	Months	Days	If less than one day
64			hr. min.

9. Birthplace Catonsville, Md. (Town, county, and state)
10. Usual Occupation domestic
11. Industry or business

FATHER 12. Name Jacob Ammenhauser
13. Birthplace Germany

MOTHER 14. Maiden Name Louise Pfeiffer
15. Birthplace Maryland

16 (a) Informant John Ammenhauser
(b) Address 822 Fred Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/4/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park.
Location Baltimore City

18 (a) Funeral director Edw. J. McGrath
(b) Address Catonsville Md.

(c) JAN 2 1946 (Date received by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-1-46 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/18/45 19 to 1/1/46 19, and that I last saw h[illegible] alive on 1/1/46 19

Immediate cause of death Pneumonia. — Duration

Due to Cellulitis of leg.

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. E. DeSanno M.D.

Address St. Joseph's Hosp. Date signed 1-1-46

PHYSICIAN
Underline the cause to which death should be charged statistically.

VS 150

G35938

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 D

Registered No. G35938

1. PLACE OF DEATH:
(a) Baltimore City, Maryland D.O.A
(b) Street address 628 George St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 628 George St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Custis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years	Months	Days	If less than one day
66			hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Not known
13. Birthplace

MOTHER
14. Maiden Name Not known
15. Birthplace

16 (a) Informant Mary Lady Father
(b) Address 1731 Dolphin St

17 (a) Burial (b) Date thereof 1-4-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location A. A. Co. Md.

18 (a) Funeral director Jesse W. Reddick
(b) Address 436 W. Biddle St

19 (a) JAN 3 1946
(Date received by registrar)

Waiting for Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/31 1945; at 2.00 P.M.

21. I certify that I took charge of the remains described above, held an Inspection-Examination thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C.V Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature G. L. Lubrinski M.D.
Medical Examiner.
Date signed 1/2/46

X

Please write the causes of death clearly and legibly. Physicians: please write as completely as possible. The following information is especially important.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35939

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1108

Registered No. D 35929.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 48 min
(e) Length of stay in Baltimore (yrs., mos., or days) 32 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4006 E. Pratt St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Miros, Frank Frank Miros

3 (b) If veteran, name war No

3 (c) Social Security Account No. 213-18-1737

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Marie Miros
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) 1/21/1914

8. AGE: Years	Months	Days	If less than one day
31	11	12	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Stanislaus Miros
13. Birthplace Poland

MOTHER
14. Maiden Name Bronislawa Fronckiewicz
15. Birthplace Poland.

16 (a) Informant Marie Miros
(b) Address 4006 E. Pratt St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-5-46 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart of Mary
Location Balto County

18 (a) Funeral director John M. Weber
(b) Address 411 S. Chester Street

19 (a) (b) Date received by registrar JAN - 3 1946 Registrar

VS 100

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/2/46 1946 at 4:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/2 1946 to 1/2 1946 and that I last saw him alive on 1/2 1946

Immediate cause of death Cardiac Embarrassment Cardiac Failure

Due to Generalized Sclerosis Coronaries

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: AS ABOVE - ALSO HEALED BILATERAL PYELONEPHRITIS

Duration
3 days ??
Coronaries ?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. D. Patton, M.D.
Address Church Home Hospital Date signed 1/3/46

Approved: Robert Lee Hunter for M. D. Patton

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35930 — BALTIMORE CITY HEALTH DEPARTMENT — G35930

CERTIFICATE OF DEATH 93D

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 800 S. Rappolo St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 2

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 713 S. Wolfe St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Krokowski

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business Weber Tailoring Co. 837 E. Balto St.

FATHER
12. Name —
13. Birthplace Poland

MOTHER
14. Maiden Name —
15. Birthplace Poland

16 (a) Informant Sophia Sanchez
(b) Address 800 S. Rappla St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-4-46 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Balto. Co.

18 (a) Funeral director Wm. S. Fialkowski
(b) Address 2007 Eastern Ave

19 (a) (Date rec'd by Registrar) (b) Registered JAN 3 1946 Huntington Hill, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 1st 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 24th 1945 to Jan 1st 1946, and that I last saw h[er] alive on Dec 8th 1945

Immediate cause of death: Pulmonary Oedema — Duration: 1

Due to: Myocardial Degeneration — Duration: Yrs.

Other Conditions: Chronic Prostatic Carcinoma — Duration: Months

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work?
(e) Means of injury —

23. Signature J. F. Reis
Address 24 S. Bonday M. D.
Date signed Jan 3/46

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G35931 ✓170 C

Registered No. G35931

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3404 Mayfield Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frauda M. Kraemer (KRECZMER)

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-26-2400

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Mary.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 27-1878

8. AGE: Years 67 | Months 4 5 | Days 5 | If less than one day ... hr. ... min.

9. Birthplace Pa
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name John Kraemer (Kraemer)
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Fitch
15. Birthplace Germany

16 (a) Informant Mary K. Lange
(b) Address 3004 Mayfield Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/5/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Hamilton
Location Balto Co.

18 (a) Funeral director Wm. Piaskowski
(b) Address 141 E. Eastern Ave

19 (a) JAN - 3 1946 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH January 2 1946, at 2:40 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death, in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Traumatic Shock

due to Compound fractures of both lower legs

Other Conditions Contusions of Head.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 26/3

(a) Date of injury January 1, 1946 M.
(b) Where did injury occur? Mayfield Ave. Brandon Trans
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Struck by auto

23. Signature Benedict Shiteroff M.D.
Medical Examiner
Date signed 1-2-46

VS 151

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. ... information should be carefully supplied. The

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

63932 — 43D — Registered No. 63946

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Fleet St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 612 S. ann St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Andrew Jacobsen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years	Months	Days	If less than one day
74			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Mrs. Schoepflin
(b) Address 3511 Denison Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan-5-45 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location A.A. Co.

18 (a) Funeral director Wm. S. Fialkowski
(b) Address 2007 Eastern Ave

19 (a) (Date rec'd by registrar) (b) Registrar

JAN 3 1946

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 2 1946, at M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-vascular disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Stotarelic M.D. Medical Examiner.
Date signed Jan 2 1946

Correct age is especially important. Physicians: please write the causes of death clearly and legibly. Name of informant should be carefully supplied. The

635933

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 635933

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Mercy Hospital
(c) Hospital or institution: Calvert & Saratoga St
(d) Length of stay in hospital or inst. (yrs., mos., or days):
(e) Length of stay in Baltimore (yrs., mos., or days): 50yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md (b) County:
(c) City or town: Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 3605 Oakmont Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country:

3 (a) FULL NAME: William Moss

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Lena
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1881

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace: Russia
(Town, county, and state)

10. Usual Occupation:
11. Industry or business: Tailor

FATHER
12. Name: Sidney Moss
13. Birthplace: Russia

MOTHER
14. Maiden Name: Rachael Schlitz
15. Birthplace: Russia

16 (a) Informant: Albert Moss
(b) Address: 3605 Oakmont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof January 4, 1946 (month) (day) (year)
(c) Cemetery or crematory: Hebrew Rosedale Cemetery
Location: Philadelphia Rd & Hamilton Ave

18 (a) Funeral director: Sol Levinson & Bros
(b) Address: 1124-1126 W North Ave

19 (a) (Date rec'd by registrar) JAN - 3 1946 (b)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 2 1946, at 10 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1943 to 1/2 1946, and that I last saw h[illegible] alive on 1/2 1946.

Immediate cause of death	Duration
Coronary Thrombosis	2 years
Due to Congestive Heart Failure	4 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: 1945 at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: Sol L. Smith
Address: 1223 E. North Ave Date signed: 1/2/46 M. D.
Balto, 2, Md. X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35934

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 73D

G35934 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 100 N Calhoun St.
(c) Hospital or institution: Franklin Square Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 938 Whitelock St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Isaac Goldman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Theresa

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years 67 66 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace: Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business: None

FATHER
12. Name: Joseph Goldman
13. Birthplace: Russia

MOTHER
14. Maiden Name: Sarah ?
15. Birthplace: Russia

16 (a) Informant: Louis Goldman
(b) Address: 938 Whitelock St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan, 4, 1946 (month) (day) (year)
(c) Cemetery or crematory: Hebrew Herring Run Cem
Location: Bowleys Lane

18 (a) Funeral director: Sol Levinson & Bros
(b) Address: 1124-1126 W North Ave

19 (a) (Date rec'd by registrar) JAN 3 1946 (b) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/3 1946, at 9:23 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/1 1945 to 1/3 1946, and that I last saw him alive on 1/3 1946.

Immediate cause of death	Duration
Cardiac failure	
Due to Hypertensive Cardio-Vascular Disease	
Due to	
Other Conditions Pneumonia	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Barbara L. Jones M. D.
Address Franklin Square Hosp. Date signed 1/3/46

Kolarik G35935

G35935

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 904 N Montford Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 904 N Montford Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine Kolarik

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Joseph Kolarik

6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) June 23, 1872

8. AGE: Years 73 | Months 6 | Days 8 | If less than one day hr. min.

9. Birthplace Newark (Town, county, and state)

10. Usual Occupation Crochet Blankets

11. Industry or business

FATHER
12. Name Joseph Gebeltka
13. Birthplace Bohemia

MOTHER
14. Maiden Name Mary Jonda
15. Birthplace Bohemia

16 (a) Informant Joseph Kolarik
(b) Address 904 N. Montford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-4-46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto Md

18 (a) Funeral director Frank Grochalski
(b) Address 900 N. Chester St

19 (a) 1946 Date rec'd by registrar Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 31 1945, at 7:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1945 to DEC 31 1945 and that I last saw alive on DEC 31 1945

Immediate cause of death Coronary Thrombosis — Duration 12/29/45

Due to Acute Myocardial I.S — 7/1/45

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signatury William J Rogan M.D.
Address 801 S Kenwood Ave Date signed 1/3/46

VS 150

G35936

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

CMK-87815

Registered No. G35936

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1- 7- 11
(e) Length of stay in Baltimore (yrs., mos., or days) 2 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 132 N. Carlton Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hattie Jackson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Separated

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25-1906

8. AGE: Years 39 | Months 11 | Days 21 | If less than one day hr. min.

9. Birthplace Kentucky
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joseph Cobb
13. Birthplace Ga.

MOTHER
14. Maiden Name Mattie McGee
15. Birthplace Ga.

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School JAN 2 1945

18 (a) Funeral director Commissioner of Health
(b) Address

JAN 3 1946 (Date rec'd by registrar) Registrar

VS 150

F 3178

MEDICAL CERTIFICATION

20. DATE OF DEATH December 16 1945, at 8:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 5 1944, to Dec. 16 1945, and that I last saw h. alive on Dec. 16 1945.

Immediate cause of death	Duration
Cardiac Failure	
Due to Hypertensive Cardiovascular Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature T. P. Jernigan M. D.
Address Baltimore City Hosp. Date signed 12-26-45

G35937
AB-197
12715

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 30c

G35937
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 yrs-6mos-27days
(e) Length of stay in Baltimore (yrs., mos., or days) 58 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 212 Otterbein St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Albert King

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife: Hattie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?-?-? ? 71 yrs

8. AGE: Years	Months	Days	If less than one day
71 ?	?	?	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name ?
13. Birthplace Md

MOTHER
14. Maiden Name ?
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School JAN 2 1945

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) JAN 3 1946 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 25- 19 45, at 10.55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-28- 1924, to 12-25 1945, and that I last saw h im alive on 12-25 1945.

Immediate cause of death	Duration
Bronchopneumonia	
Due to	
Due to	
Other Conditions C.N.S. Syphilis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: none
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature T. P. Jennigon M. D.
Address Baltimore City Hosp Date signed 12-28-45

VS 150

3179

107

G35938

JL - 97892

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G35938 / 108

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals 41

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days

(e) Length of stay in Baltimore (yrs., mos., or days) 8 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 48 Market Place (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jack Jamison

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 16, 1898

8. AGE: Years	Months	Days	If less than one day
47	5	1	hr. min.

9. Birthplace Pa. (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER

12. Name Samuel Jamison

13. Birthplace Pa.

MOTHER

14. Maiden Name Elizabeth Jones

15. Birthplace Ireland

16 (a) Informant B. C. H. Records

(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory Location Johns Hopkins Medical School JAN 2 1945

18 (a) Funeral director Commissioner of Health

(b) Address

JAN 3 1946 (Date rec'd by registrar) Hunting for Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 16 1945 11.40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 15 1945 to Dec 16 1945, and that I last saw h. alive on Dec. 16 1945

Immediate cause of death Lobar pneumonia — Duration ?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Margaret M. Dorsey M. D.

Address 4940 Eastern Ave. Date signed 12/21/45

3180

635939

CWK-91303

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83B

Registered No. 635949

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Avenue

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11- 17

(e) Length of stay in Baltimore (yrs., mos., or days) 13 Yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 5311 York Road (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Lovey Harris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Separated

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 24-1892

8. AGE: Years	Months	Days	If less than one day
53	8	20	hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Coleman Harris

13. Birthplace Virginia

MOTHER

14. Maiden Name Betty Carter

15. Birthplace Virginia

16 (a) Informant Records-Balto. City Hospitals

(b) Address 4940 Eastern Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location Johns Hopkins Medical School JAN 2 1946

18 (a) Funeral director Commissioner of Health

(b) Address

JAN 3 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION P

20. DATE OF DEATH December 14 1945, at 6:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 27 1944, to Dec. 14 1945, and that I last saw him alive on Dec. 14 1945

Immediate cause of death	Duration
Bronchopneumonia	
Due to Cerebral Thrombosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature T. B. Jervigor M. D.

Address Baltimore City Hosp. Date signed 12-26-45

VS 150

3181

635940

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered 635940

TN. 77182

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Fill in correct age in years. If less than one year, write months, days, hours, or minutes. If unknown, write UNK. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3- 2- 14
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Tormollans Shore
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Hetzler

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 20th 1872

8. AGE: Years	Months	Days	If less than one day
72	9	28	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name John Hetzler (D
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Breinlein (D
15. Birthplace Tormollans Shore

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Johns Hopkins Medical School JAN 2 1946

18 (a) Funeral director Commissioner of Health
Address
JAN 3 1946 Thomas Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 18th 1945 19 5.00 at P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 5th. 42 to Dec 18 19 45, and that I last saw him alive on Dec 19th 19 45

Immediate cause of death Bronchopneumonia — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: none
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature T. P. Jerpigan M. D.
Address Baltimore City Hosp Date signed 12-26-45

VS 150

3182

G35941

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 B

Registered No. G35941

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10yrs-11mos-
(e) Length of stay in Baltimore (yrs., mos., or days) 65yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 733 Ajax Alley
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sam Kellam

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Eleanor

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 20-1871

8. AGE: Years	Months	Days	If less than one day
74	4	6	....hr. ....min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation Laborer -Huckster

11. Industry or business

FATHER
12. Name Samuel Kellam
13. Birthplace Va.

MOTHER
14. Maiden Name Anne Ames
15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) ....(Burial, cremation, or removal) (b) Date thereof ....(month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School JAN 2 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 JAN 3 1946 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 26 1945, at 12.10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-26- 1935, to 12-26- 1945, and that I last saw him alive on 12-26- 1945.

Immediate cause of death: Pulmonary Tuberculosis — Duration: 2

Due to

Due to

Other Conditions: Arterio Sclerotic Cardio-Vascular Disease
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No Post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ....at .... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Herbert B. Ogleby Jr. M.D.
Address Balt. City Hosp. Date signed 1/29/46

VS 150

3183

G35942

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No. G35942

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address University Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17da
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2022 N. Calvert St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Florence CHAPMAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1909

8. AGE: Years	Months	Days	If less than one day
36			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name No relatives
13. Birthplace

MOTHER
14. Maiden Name No relatives
15. Birthplace

16 (a) Informant Sue Lord
(b) Address 2022 N. Calvert St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location Johns Hopkins Medical School JAN 2 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 JAN 3 1946 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-23 1945 at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/6 1945 to 12/23 1945 and that I last saw her alive on 12/23 1945

Immediate cause of death: Respiratory failure — Duration

Due to: generalized hypoproteinemia and malnutrition.

Due to: Probable generalized abd. carcinomatosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 12-[illegible]3

Major findings of operation: Fluid in abd. exact cause not explained

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Douglas E. Bradshaw M. D.
Address Univ. Hospital Date signed 1-2-46

VS 150

3177 BRADSHAW X

G35943

481341

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1579

Registered No. G35943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Every death certificate is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va. (b) County
(c) City or town Rumberport. (If outside city or town limits, write RURAL and give town)
(d) Street No. Rt. Box 26. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME • Hadley Jenks Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-16-45

8. AGE: Years | Months: 7 | Days: 17 | If less than one day: hr. min.

9. Birthplace W. Va. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Hadley Jenks.
13. Birthplace Mr.

MOTHER
14. Maiden Name Victoria Moore
15. Birthplace W. Va.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial, cremation, or removal (b) Date thereof 1/4/46 (month) (day) (year)
(c) Cemetery or crematory Shannahan
Location Shannahan Ave & Co

18 (a) Funeral director Mulhern & Co
(b) Address 2114 East St

19 (a) (Date rec'd by registrar) JAN -3 1946 (b) Huntington, W. Va.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan - 3 1946, at 3.10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct - 2 - 1945 to Jan - 3 1946, and that I last saw him alive on Jan - 3 1945.

Immediate cause of death	Duration
Respiratory failure	
Due to Liver damage	
Due to Congenital atresia of common bile duct	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 1 - 1 - 46

Major findings of operation: Congenital absence of bile duct

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harrison Clark Spencer M. D.
Address Johns Hopkins Hosp. Date signed 1-3-46

X

G35944 BALTIMORE CITY HEALTH DEPARTMENT G35944

CERTIFICATE OF DEATH

Registered No. 107

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison + Linden
(c) Hospital or institution: Maryland General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Sparrows Point
(If outside city or town limits, write RURAL and give town)
(d) Street No. 729 Maddison Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harvey R. Harris

3 (b) If veteran, name war: W
3 (c) Social Security Account No. 213-07-0774

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married 213-07-0774

6 (b) Name of husband or wife Naomi D
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 14. 1905

8. AGE: Years	Months	Days	If less than one day
40	4	19	hr. min.

9. Birthplace Millville N J (Town, county, and state)
10. Usual Occupation Oiler
11. Industry or business Bethlehem Steel Co

FATHER
12. Name Harvey Harris
13. Birthplace Fort Harris N J

MOTHER
14. Maiden Name Emma Simmerman
15. Birthplace Enola N J

16 (a) Informant Naomi Harris
(b) Address Sparrows Point Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/5/46 (month) (day) (year)
(c) Cemetery or crematory Mount Olivet
Location Millville N J

18 (a) Funeral director Milton Ortt Sr
(b) Address 1219 Fort Ave

19 (a) 1946 (b) Registered by registrar Harrington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/3/46 19 , at 11 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 , to 19 , and that I last saw h alive on 19

Immediate cause of death	Duration
Bronchopneumonia	
Due to	
Due to	
Other Conditions Bronchiectasis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Martin E. Strobel M. D.
Address Md. Gen'l. Hospital Date signed 11/3/46

G35945

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170 C

G35945 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1626 Eutaw Place (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bonnie M. Kuhl

3 (b) If veteran, name war: W

3 (c) Social Security Account No. 232-36-4628

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 13 1919

8. AGE: Years 26 | Months 2 | Days 19 | If less than one day hr. min.

9. Birthplace Brighton Co. Md (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business McCormick Co

FATHER
12. Name Roy Kuhl
13. Birthplace Md

MOTHER
14. Maiden Name Ruth Fitzpatrick
15. Birthplace Md

16 (a) Informant Roy Kuhl
(b) Address Emmitsburg Md

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 1/4/46 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore Md

18 (a) Funeral director Gilbert & Son
(b) Address 12 N. Paca St.

19 (a) 1-3-46 (Date rec'd by registrar) (b) Wilmington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-2-1946 at 8:02 P M

21. I certify that I took charge of the remains described above, held an Inspection Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Skull; Multiple Lacerations Head & body.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1/2/46 at 2 P.M. 24 hr
(b) Where did injury occur? Key Highway & Cross St
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Auto into Fixed Object

23. Signature Balt City Chief Medical Examiner M.D.
Date signed 1-2-46

Please see that the information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G35946 BALTIMORE CITY HEALTH DEPARTMENT G35946
Registered No.

CERTIFICATE OF DEATH V 186a

Every item of information should be carefully supplied. Type or write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 715 N. Pulaski St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gorman H Stevens

3 (b) If veteran, name war NO
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife Gladys
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 8 1914
8. AGE: Years 31 Months 0 Days 24 If less than one day hr. min. 30
9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Mechanic
11. Industry or business Gas + Electric Co

FATHER
12. Name William J Stevens
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Anna Green
15. Birthplace Baltimore Md

16 (a) Informant Gladys Stevens
(b) Address 715 N Pulaski St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/5/46 (month) (day) (year)
(c) Cemetery or cemetary Mt Olivet
Location Baltimore Md

18 (a) Funeral director Wilhelm & Son Inc
(b) Address 1217 E Fort Ave

19 (a) JAN 3 1946 (Date received by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION 46

20. DATE OF DEATH January 2 1945, at 12:15 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Intracranial Hemorrhage, traumatic

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 25/3
(a) Date of injury January 2, 1945
(b) Where did injury occur? 210 Kloman St, Private Industrial
(c) Did injury occur at home, on farm, industrial place, in public place? While at work? Yes
(d) Means of injury Fell from scaffolding

23. Signature [illegible] M.D.
Medical Examiner.
Date signed Jan. 3, 1945

635947

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 130

635947 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1143 Way St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosa McKee.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	Black	Married

6 (b) Name of husband or wife John Lee McKee

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9.9.21.

8. AGE: Years	Months	Days	If less than one day
24.	3	22	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business Housewife.

FATHER
12. Name George Mathews.
13. Birthplace Md.

MOTHER
14. Maiden Name Rosie Johnson
15. Birthplace Va.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 1/7/46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Arlington Mem. Pk.
Location Elroy O. Wilson

18 (a) Funeral director
(b) Address 1000 Brantley ave

19 (a) JAN - 4 1946
(Date received by registrar) Registrar

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 12.31 1945 at 12 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12.14 1945 to 12.31 1945 and that I last saw her alive on 12.31 1945

Immediate cause of death	Duration
ACUTE GLOMERULONEPHRITIS WITH UREMIA	1 YEAR
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations:
of autopsy: AS ABOVE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature S. P. Asper Jr. M.D.
Address Johns Hopkins Hospital Date Dec 31, 1945

X

G35948

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G35948
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1501. W. Franklin
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1501. W. Franklin
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence Gough

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race Col

6 (a) Single, married, widowed, or divorced M

6 (b) Name of husband or wife Vencie Gough

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 13-1890

8. AGE: Years 45 | Months 2 | Days 19 | If less than one day hr. min. 1900

9. Birthplace Baltimore (town, county, and state)

10. Usual Occupation Chauffeur

11. Industry or business Tobacco

FATHER
12. Name Alexander Gough
13. Birthplace Md

MOTHER
14. Maiden Name Charlotte Cutler
15. Birthplace Md

16 (a) Informant Vencie Gough
(b) Address 1501. W. Franklin

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 7-46 (month) (day) (year)

(c) Cemetery or crematory New Cathedral
Location Baltimore

18 (a) Funeral director Sam'l. J. Chase & Son
(b) Address 638. N. Gilmor St

19 (a) (Date rec'd by registrar) (b) Registrar

JAN 4 1946 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 3 1946, at 8:27 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12-10 1945 to 1-3 1946, and that I last saw h alive on Jan 3 1946

Immediate cause of death

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles J. Wendt M. D.

Address 861 Park Ave Date signed 1-5-46

X

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35949 | BALTIMORE CITY HEALTH DEPARTMENT | G35949

CERTIFICATE OF DEATH 1946 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address E. 33rd St.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-0-A
(e) Length of stay in Baltimore (yrs., mos., or days) 50 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 523 E. 38th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Robert Dixon Davis

3 (b) If veteran, name war ---

3 (c) Social Security Account No. 213-14-8293

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ella B. Davis

6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) Aug. 25, 1869

8. AGE: Years 76 | Months 4 | Days 8 | If less than one day ..... hr. ..... min.

9. Birthplace Frederick Md. (Town, county, and state)

10. Usual Occupation Painter

11. Industry or business

FATHER
12. Name Archibald T. Davis
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs. Ella B. Davis
(b) Address 523 E. 38th. St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 5, 1946 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Balto. Md.

18 (a) Funeral director Robert S. Little
(b) Address 2700 Edmondson Ave.

19 (a) JAN - 4 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-3- 1946, at 6:20 A.M.

21. I certify that I took charge of the remains described above, held an Inspection & Inquest thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to Arteriosclerotic changes

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury .....

23. Signature Howard J. Madden M.D. (Medical Examiner)
Date signed 1-3-46

VS 151

Huntington Williams, M.D.

G35950 BALTIMORE CITY HEALTH DEPARTMENT G35950

CERTIFICATE OF DEATH 195E

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 695 W. M (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph Cornish

3 (b) If veteran, name war: War #1
3 (c) Social Security Account No.:
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: none
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): 1895
8. AGE: Years 50 | Months | Days | If less than one day hr. min.
9. Birthplace: Balto. Md. (Town, county, and state)
10. Usual Occupation: Laborer.
11. Industry or business:
FATHER 12. Name: William Cornish
13. Birthplace: Md.
MOTHER 14. Maiden Name: Frannie Davis
15. Birthplace: Md.
16 (a) Informant: Agnes Waters
(b) Address: 695 - W. Mulberry St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 1-4-46 (month) (day) (year)
(c) Cemetery or crematory: Balto. Nat. Cem.
Location:
18 (a) Funeral director: Adolphus Halstead
(b) Address: 918 - Druid Hill Ave.
19 (a) (Date rec'd by registrar) (b) Huntingtor Williams, M.D.

VS-1a JAN - 4 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 27 1945, at 5:12 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Crushed skull

Due to:

Other Conditions: Compound fracture right arm (Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Dec. at 27, 1945 4:2 M.
(b) Where did injury occur? 755½ W. Mulberry
(c) Did injury occur at home, on farm, industrial place, in public place? Home. While at work? Yes.
(d) Means of injury: Wall collapsed.
23. Signature: Benedict Skitarelic M.D. Medical Examiner.
Date signed 12-28-45

X

G35954

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G35951
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division st
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 Months

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County A. An Co.
(c) City or town Brooklyn
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Marilyn Burrell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced. –

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 10-45

8. AGE: Years | Months: 4 | Days: 21 | If less than one day: hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Earl Burrell
13. Birthplace md

MOTHER
14. Maiden Name Alverta Williams
15. Birthplace

16 (a) Informant Earl Burrell
(b) Address Brooklyn md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 4-46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location

18 (a) Funeral director James A Hayes
(b) Address 142 W Biddle St

19 Filed Jan 4 1946 (b) Huntington Williams, M.D. Registrar
(Date received by Local Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-31 19 45 at 8.55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-30 19 45 to 12-31 19 45 and that I last saw h.e.r alive on 12-31 19 45

Immediate cause of death Lobar pneumonia

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

Duration one week (interval)

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C.R. Campbell M.D.
Address 718 Dolphin St. Date signed 1-3-46

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

63592 — BALTIMORE CITY HEALTH DEPARTMENT — 93D — Registered No. 63592

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2705 Westwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 76 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2705 Westwood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Kehoe

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: none

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Anna F. Kehoe

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 28, 1862

8. AGE: Years 83 | Months 9 | Days 4 | If less than one day: hr. min.

9. Birthplace: Ireland (Town, county, and state)

10. Usual Occupation: Retired

11. Industry or business

FATHER — 12. Name: Thomas Kehoe
13. Birthplace: Ireland

MOTHER — 14. Maiden Name: - Murphy
15. Birthplace: Ireland

16 (a) Informant: Mary May Hooker
(b) Address: 2705 Westwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/5/46 (month) (day) (year)
(c) Cemetery or crematory: New Cathedral Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) JAN - 4 1946 (Date rec'd by registrar) (b) Huntington Willis

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 Jan 1946, at 7:15 P M

21. I certify that I took charge of the remains described above, held an Inquest thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Arteriosclerotic Cardio Vascular disease

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature William L. Belfrick M.D. Medical Examiner
Date signed 3 Jan 46

X

Meiser

635953

635953

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V94a

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto. Gen. Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) D-0-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3308 Fairview ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Louis T. Meiser Sr.

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	216-10-8841

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Eva E. Meiser
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 13, 1883

8. AGE: Years	Months	Days	If less than one day
62	10	19	hr. min.

9. Birthplace Baltimore Co., Md.
(Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business John C. Cowan Son

FATHER
12. Name Jacob J. Meiser
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mr. Louis T. Meiser, Jr.
(b) Address 2829 Riggs Ave.

17 (a) Burial (b) Date thereof 1/5/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

JAN - 4 1946

19 (a) (b)
(Date rec'd by registrar) Registrar, Md.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 - 2 - 1946 at 8 a.m.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 1-2-46

G35954 G35954

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green
(c) Hospital or institution:
Univ. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2731 Parkwood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur Cragg

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 29, 1888

8. AGE: Years	Months	Days	If less than one day
57	1	3	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name John I. Cragg
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Emma C. Weissner
15. Birthplace Balto., Md.

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (b) Date thereof 1/5/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.
18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.
19 (a) JAN -4 1946 (b)
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 2 1946, at 6.50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-1 1946, to 1-2 1946, and that I last saw him alive on 1-2 1946

Immediate cause of death	Duration
Lobar Pneumonia, Rt	
Lower Lobe & L. Lower Lobe	
Due to Toxemia	
Dehydration	
Due to	
Other Conditions None	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Eugene R. Conner M.D.
M. D.
Address Univ. Hospital Date signed 1-2-46

63595 BALTIMORE CITY HEALTH DEPARTMENT 63595
CERTIFICATE OF DEATH 131a
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2558 Rutt Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 d
(e) Length of stay in Baltimore (yrs., mos., or days) 63 10 29 Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2558 Rutt St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) **FULL NAME** ANNA ELIZABETH (BESSIE) BROWN

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: None

4. Sex: F
5. Color or race: W.
6 (a) Single, married, widowed or divorced: Widowed

6 (b) Name of husband or wife: James A. Brown Deceased
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/5/1858

8. AGE: Years 63 | Months 10 | Days 29 | If less than one day hr. min.

9. Birthplace Baltimore City (Town, county and state)
10. Usual Occupation Retired Housewife
11. Industry or business Home

FATHER
12. Name David D. Wingrove
13. Birthplace U.S.A. (Md. or Penn?)

MOTHER
14. Maiden Name Clara Belle Streeter
15. Birthplace Baltimore - U.S.A.

16 (a) Informant Mrs. Francis Asa Tumminello
(b) Address 2558 Rutt St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/5/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JAN - 4 1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 3 1946 at 4 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1936 to 1/3 1946 and that I last saw h[illegible] alive on 12/15 1945.

Immediate cause of death: Coronary Thrombosis — Duration: Minutes

Due to: Hypertensive Cardio Renal Vascular Disease — Duration: 11 years

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature W. Grafton Derberger M. D.
Address 214 Medical Arts Bldg Date signed 1/3/46

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G3596 — BALTIMORE CITY HEALTH DEPARTMENT — G3596 Registered No. 95c

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2705 Miles Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2705 Miles Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE BIERLEY

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Annie Bierley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 21, 1864

8. AGE: Years	Months	Days	If less than one day
81	3	10	hr. min.

9. Birthplace Parkton, Md.
(Town, county, and state)
10. Usual Occupation Retired Park Officer
11. Industry or business Park Board

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs. G. S. Core
(b) Address 3302 Alto Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/4/46 (month) (day) (year)
(c) Cemetery or crematory St. Mary's Cem.
Location Hampden

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JAN - 4 1946 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 1, 1946, at 8:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1946 to Jan 1 1946 and that I last saw him alive on Jan 1 1946.

Immediate cause of death Cardiac Insufficiency — Duration ?
Due to Generalized Arteriosclerosis — ?
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel Core M. D.
Address 1701 E Mount Date signed 1/7/46

VS 13 For O. B. Davis, by Howard J. Mullen, M. D.

635958 — 635957

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 33A

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 104 Enfield Rd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 104 Enfield Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

12

3 (a) FULL NAME Katie F. Gerbig

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Geo Gerbig
6 (c) If alive, give age D years

7. Birth date of deceased (mo., day, yr.) April 16, 1860

8. AGE: Years	Months	Days	If less than one day
85	8	13	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Tobias Borne
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Miss Catherine Gerbig
(b) Address 104 Enfield Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/4/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Ave

18 (a) Funeral director John F Denny Inc
(b) Address 718 Light St.

19 (a) (Date received) (b) Registrar

JAN 4 1946 Lexington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 1st 1946, at 6:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 22 19 45 to Jan 1 1946 and that I last saw h[illegible] alive on Dec 31 1945

Immediate cause of death	Duration
Capillary Bronchitis	
Due to Following Grippe Cold	
Due to Age	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations None
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence None at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature John F Evans M. D.
Address 612 N 40 St Date signed

X

G35958 BALTIMORE CITY HEALTH DEPARTMENT G35958

CERTIFICATE OF DEATH

160a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: W Balt. Gen'l Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Howard
(c) City or town Elk Ridge
(If outside city or town limits, write RURAL and give town)
(d) Street No. / Hawthorne Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Baby Girl Dusty

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace W. Balt Gen'l Hosp.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name James H. Dusty
13. Birthplace Washington, D.C.

MOTHER 14. Maiden Name Mildred M. Uphdyll
15. Birthplace Balt. Md.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School JAN 2 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 JAN 4 1946 Hunter Kerr Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 30 1945; at 1 45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 29 1945, to Dec. 30 1945, and that I last saw her alive on Dec 30 1945

Immediate cause of death: Intracranial Hemorrhage — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. Schenfeld M.D.
Address West Balt. Gen. Hosp. Date signed 12/30/45

5187

VS 150

G35959

485373

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓108

G35959 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 733 S. Broadway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Florence Chamber

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-1-45

8. AGE: Years | Months: 6. | Days: 19 | If less than one day: hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Russell Chamber
13. Birthplace ?

MOTHER
14. Maiden Name Ruciille ?
15. Birthplace ?

16 (a) Informant Rhonda.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School JAN 2 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 JAN 4 1946 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec - 20 1945, at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec - 17 1945 to Dec - 20 1945 and that I last saw him alive on Dec - 20 1945,

Immediate cause of death Respiratory failure — Duration

Due to Pneumonia (Type 15) - 10 hr

Due to Acute Nutritional Disturbance
Malnutrition

Other Conditions ? Encephalitis
Sclerema

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harrison Clarke Spencer M. D.
Address Johns Hopkins Hosp Date signed 12-20-45

VS 150

3186

X

635960D

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

635960 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hospital 23
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day.
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1109 S. Charles St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Cook

3 (b) If veteran, name war /

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/26/45

8. AGE: Years	Months	Days	If less than one day
			8 hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Major Cook
13. Birthplace Md.

MOTHER 14. Maiden Name Ethlean Ballard
15. Birthplace Md.

16 (a) Informant Ethlean Cook
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory Johns Hopkins Medical School JAN 2 1946

18 (a) Funeral director Commissioner of Health

(b) Address

JAN 4 1946 (Date rec'd by registrar) H. Bentley Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/26 1945; at 10:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 12/26 1945, to 12/26 1945, and that I last saw her alive on 12/26 1945.

Immediate cause of death	Duration
Atelectasis, bilateral, partial	
Due to prematurity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robert Mark MD M. D.

Address University Hosp. Date signed 12/26/45

VS 150

3185

X

G35961

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No. G35961

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1012 Granby Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Janos Gatusori (John Matis)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years	Months	Days	If less than one day
59			hr. min.

9. Birthplace
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School JAN 3 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 JAN 4 1946 Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 19, 1945 at 2 A. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH arteriosclerotic cardiovascular disease

Due to

Other Conditions
(Include pregnancy within 2 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Gutarski M.D.
Medical Examiner.
Date signed 12-19-45

VS 151

3190 X

G35962

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G35962 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Washington (b) County
(c) City or town Tacoma
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1412 14th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clayton R - Shagara

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years 60 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Johns Hopkins Medical School JAN 3 1946

18 (a) Funeral director Commissioner of Health
(b) Address

19 JAN 4 1946 Huntington Williams M.D. Registrar.
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 26 1945, at 10:30 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Lobar Pneumonia

Due to

Other Conditions
(Include pregnancy within 3 months of death)

If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert R. Fraser M.D.
Medical Examiner.
Date signed 12-26-45

E-3180

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. TYPE OR PRINT WITH UNFADING INK.

G35963 G35963

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRINT OR WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital 3-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-0-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 620 N. Broad St. 3rd floor
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Smolinsky

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	—

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years	Months	Days	If less than one day
75			hr. min.

9. Birthplace
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Local Johns Hopkins Medical School JAN 3 1946

18 (a) Funeral director Commissioner of Health
(b) Address

JAN 4 1946 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-18- 1945; at 9 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardio-vascular Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mellers M.D.
Medical Examiner.
Date signed 12-18-45

VS 151

3188 X

635964

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1945

635964 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2915 N. Paul St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2915 N. Paul St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lina Getschel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: W.

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: late John G.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 1, 1858

8. AGE: Years 87 | Months 2 | Days 1 | If less than one day hr. min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name John Preis
13. Birthplace Germany

MOTHER
14. Maiden Name Rosena Strauss
15. Birthplace Germany

16 (a) Informant Johanna Getschel
(b) Address 2915 N. Paul St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 5/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location 3801 Fredrick Rd.

18 (a) Funeral director Harry H. Nitzke
(b) Address 4101 Edmondson Ave

19 (a) [illegible] (b) Jan 4 1946 Lizzie Williams Registrar

MEDICAL CERTIFICATION 46

20. DATE OF DEATH Jan 2nd 1945 at 11:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1940 to Jan 2nd 1945 and that I last saw h[illegible] alive on Jan 2nd 1945

Immediate cause of death: Myocardial Insufficiency Arteriosclerosis Diabetes Mellitus Heart Failure — Duration: 5 years, Many

Due to: Arteriosclerosis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. A. Getschel M. D.
Address 300 N. Charles St Date signed Jan 3 1946

G35965

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G35965 Registered No. 1

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2712 Pennsylvania Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Johanna Gleason

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 8, 1885

8. AGE: Years	Months	Days	If less than one day
60	7	25	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Roger Gleason
13. Birthplace Ireland

MOTHER
14. Maiden Name Winifred Butler
15. Birthplace Ireland

16 (a) Informant Philip J. Gleason
(b) Address 2712 Penna. Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 / 5 / 46 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Martin Haley & Sons
(b) Address 1827 W. North Ave.

19 (a) Huntington Williams, Registrar (Date rec'd by registrar)

JAN 4 1946
VS 1st

MEDICAL CERTIFICATION

20. DATE OF DEATH January 3, 1946 at 1:30 P.M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardio-vascular disease

Due to

Other Conditions Gangrene of extremities
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Sbitarelli M.D. Medical Examiner.
Date signed 1-3-46

G35966

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 137

G35966
Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calhoun & Fayette Sts.
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital, if not. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 208 S. Carey st.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George B. Hoff

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Ethel

6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) Dec 29 - 1921

8. AGE: Years	Months	Days	If less than one day
24		5	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Chauffeur
11. Industry or business Belle Pl. Laundry Co.

FATHER
12. Name William J. Hoff
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Blanche E. Burns
15. Birthplace Baltimore Md

16 (a) Informant Mrs. Ethel Hoff
(b) Address 208 S. Carey St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/7/46 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Ave.

18 (a) Funeral director John J. Bowan & Son
(b) Address 901-03 E. Baltimore St.

19 (a) (Signature of local registrar) (b) Huntington Williams M.D. Registrar

JAN 4 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 3 - 1946, at 4:50 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute cardiac failure

Due to Hypertensive cardio-vascular disease.

Other Conditions Old myocardial infarct.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Benedict Skotarchic M.D.
Medical Examiner.
Date signed 1-3-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35967

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G35967
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3507 W. Garrison Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-18
(e) Length of stay in Baltimore (yrs., mos., or days) 16 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3507 W. Garrison Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Angiolina Pallini

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband ~~Xxxx~~ Salvatore Pallini
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 12 1880

8. AGE: Years 65 | Months 9 | Days 21 | If less than one day hr. min.

9. Birthplace Pitigliano Italy
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business home

FATHER
12. Name Pasquale Perilini
13. Birthplace Italy

MOTHER
14. Maiden Name Felicissima Liberati
15. Birthplace Italy

16 (a) Informant Salvatore Pallini (Husband)
(b) Address 3507 W. Garrison Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 5 1946 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd. Balti Md.

18 (a) Funeral director Arauld Della Rose
(b) Address 52 N. Morley St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 15 JAN - 4 1946

MEDICAL CERTIFICATION A.

20. DATE OF DEATH January 3, 1946, at 1:30/M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 2, 1946 to Jan. 3, 1946, and that I last saw h er alive on Jan. 3, 1946.

	Duration
Immediate cause of death: Coronary Thrombosis	1 day
Due to: Arteriosclerosis	Unknown
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Philip A. Artigiani M.D.
Address 2942 E. Fayette St. Date signed 1/4/46

G35968

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G35968
Registered No.

PRESS WRITE FIRMLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 5-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits write RURAL and give town)
(d) Street No. 1039 N. Front St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick Falk

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Ida E. Falk

6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) Sept. 16, 1890

8. AGE: Years 55 | Months 3 | Days 19 | If less than one day ____ hr. ____ min.

9. Birthplace Balto, Md.
(town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace " "

MOTHER 14. Maiden Name Unknown

15. Birthplace " "

16 (a) Informant Ida E. Falk

(b) Address 1039 N. Front St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1 Jan 1946 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary Cem.

Location Balto. Md.

18 (a) Funeral director Bryant Mamie E. Woolford

(b) Address 721 Pennsylvania Ave. Baltimore, Md.

19 (a) JAN 4 (Date rec'd by registrar) (b) 1946 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 Jan 1946; at 12:20 M

21. I certify that I took charge of the remains described above, held an Inspection Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic - Cardio Vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature William J. Helfrich M.D.
Medical Examiner.

Date signed 1 Jan. 46

VS 151

G35969

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G35969
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1114 Chilton st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1114 Chilton st (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Ferguson Gray

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1899

8. AGE: Years	Months	Days	If less than one day
47			hr. min.

9. Birthplace A. A. Co. Md.
(Town, county, and state)

10. Usual Occupation Housemaid

11. Industry or business

FATHER
12. Name Aaron Mundle
13. Birthplace Charles Co Md.

MOTHER
14. Maiden Name Lucy Hawkins
15. Birthplace Md.

16 (a) Informant Essie Asbury
(b) Address 621 Dolphin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 4 '46 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

JAN 4 1946 Huntington Williams M.D.
Date rec'd by Local Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 1 1946, at 7 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 27 1945, to Jan 1 1946, and that I last saw h alive on Jan 1 1946

Immediate cause of death Fetal pneumonia — Duration 8 da

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 735 E Lanvale Date signed 1/4/46

635970

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

635970 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 746 W Fairmount Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 746 W Fairmount
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Hawkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Daisy Taylor

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years 63 | Months 62 | Days | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER: 12. Name John Hawkins
13. Birthplace New Kent Co. Va.

MOTHER: 14. Maiden Name Sarah Jane Galloway
15. Birthplace Calvert Co. Md.

16 (a) Informant Daisy Taylor
(b) Address 746 W. Fairmount Ave.

17 (a) Burial (b) Date thereof Jan. 5 '46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 222 N. Schroeder St.

19 (a) JAN 4 1946 (Date received by registrar) (b) Huntington for Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 1 1946, at 7A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 26 1945, to Jan 1 1946, and that I last saw h alive on 19

Immediate cause of death: Coronary Thrombosis — Duration 3 Mths

Due to: Arteriosclerosis — Duration

Due to: — Duration

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Gatsay M. D.

Address 746 W Fairmount Ave Date signed 1/3/46

63971

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V939

63971 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 505 N. Gilmor St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and name town)
(d) Street No. 505 N. Gilmor St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Adeline Stokes

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 22, 1858

8. AGE: Years 87 | Months - | Days 9 | If less than one day ... hr. ... min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Hurfe

11. Industry or business

FATHER 12. Name Richard Stokes

13. Birthplace Va

MOTHER 14. Maiden Name ?

15. Birthplace

16 (a) Informant Annie Taylor

(b) Address 505 N. Gilmor St

17 (a) Burial (b) Date thereof Jan. 5 '46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Dr. Peter Memorial

Location

18 (a) Funeral director Mrs. Katie R. William

(b) Address 322 N. Schroeder St

19 (a) Jan 1 1946 (b) Huntington Williams M.D.
(Date rec'd by Registrar) (Signature of Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/31/1945 at 9.12 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/19/1945 to 1/31/1945 and that I last saw her alive on 1/31/1945.

Immediate cause of death: Chronic Myocarditis — Duration 1 yr.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. B. Hawkins

Address 456 W Biddle St Date signed 1/4/1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35972

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V159

G35972 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St.
(c) Hospital or institution: Sinai 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 11 hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 817 McKeen St-2
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gorman Wise McCullough

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 2-46

8. AGE: Years | Months | Days 1 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Gorman Hollowell McCullough

13. Birthplace Md

MOTHER 14. Maiden Name Lanespre Wise Nelson

15. Birthplace W. Va

16 (a) Informant Mother

(b) Address 817 McKeen St.

17 (a) Burial (b) Date thereof Jan 4-46
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Pikesville Grove Cem.

Location Pikesville Md

18 (a) Funeral director C. Dell Funeral Home Inc.

(b) Address 4644 York Road

19 JAN - 4 1946 (b)
(Date rec'd by Registrar) Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/2 1946, at 820 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/2 1946 to 1/2 1946 and that I last saw h— alive on 1/2 1946

Immediate cause of death Cardio-respiratory failure — Duration

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Prematurity (Gross)

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Marvin Rudo M. D.

Address Sinai Hosp. Date signed 1/3/46

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G35973 | Registered No. G35973

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 48 E. Mort Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 48 E. Mort Ave (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country —

3 (a) FULL NAME Elizabeth Norfolk
3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife John S. Norfolk
6 (c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) Feb. 14, 1882

8. AGE: Years	Months	Days	If less than one day
63	10	21	hr. ..... min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business —

FATHER
12. Name Christopher Schafer
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Frances Hornung
15. Birthplace Baltimore Md.

16 (a) Informant John S. Norfolk (Husband)
(b) Address 48 E. Mort Ave, Balto. 30, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 5, 1946 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem.
Location G. R. Co., Md.

18 (a) Funeral director G. Edward Evans
(b) Address 1409 E. Chase St., Balto. 39, Md.

19 JAN - 4 1946 (Date rec'd by registrar) (b) Thurlington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 2, 1946 at 1:20 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1940 to Jan 2 1946 and that I last saw her alive on Jan. 2, 1946.

Immediate cause of death Cerebral Hemorrhage

Due to (a) Hypertension Arteriosclerosis

Due to (b) Hypertension Cardiovascular Disease

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? .....
(e) Means of injury .....

23. Signature N. P. Fontana
Address 1319 Light St. Date signed 1/4/46

VS 150

X

C35974

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 C

Registered No. 35974

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 So Light St.
(c) Hospital or institution: So. Balto. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 38 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1602 S. Charles St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Edith G. [redacted] Koontz

3 (b) If veteran, name war: No
3 (c) Social Security Account No. 216-12-5446

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Harry F. Koontz
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 22 1875

8. AGE: Years 70 | Months 5 | Days 10 | If less than one day ... hr. ... min.

9. Birthplace Anne Arundel Co (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Frank [redacted] White
13. Birthplace Md

MOTHER
14. Maiden Name Dora Brown
15. Birthplace Md

16 (a) Informant William Koontz (Son)
(b) Address 7 N. Randall St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 5 1946 (month) (day) (year)
(c) Cemetery or crematory Cedar Park Cem
Location Govans

18 (a) Funeral director C. Harold Evans
(b) Address 1424 N. Charles St

19 (a) JAN - 4 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 2 1946, at 9:27 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 2 1946, to Jan 2 1946, and that I last saw him alive on Jan 2 1946.

Immediate cause of death	Duration
Cardiac failure	?
Due to Pulmonary edema	
Due to Rheumatic Cardio-	
Due to vascular disease - Chronic	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. Breck M. D.
Address 1213 Light St Date signed 1-3-46

X

G35975

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1946

Registered No. G35975

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1835 Hanover St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 23
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 1835 S Charles (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Annie W. Welsh

3 (b) If veteran, name war No

3 (c) Social Security Account No. 217-01-3213

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 27, 1880

8. AGE: Years 65 | Months | Days 4 | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER 12. Name John Welsh
13. Birthplace Ireland

MOTHER 14. Maiden Name Catherine Feeley
15. Birthplace Ireland

16 (a) Informant Mrs Catherine A. Wardell
(b) Address 1835 Hanover St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 5 1946 (month) (day) (year)
(c) Cemetery or crematory Western
Location Balto

18 (a) Funeral director A. Howard Evans
(b) Address 140 S Charles St

19 JAN - 4 1946 (Date rec'd by registrar) (b) Huntington Wilson, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 1, 1946, at 5a M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1945 to Jan 1 1946. and that I last saw her alive on Dec 31 1945

Immediate cause of death Cerebral Hemorrhage — Duration

Due to Hypertension Cardio Vascular Disease

Due to

Other Conditions Gangrene - Right Foot

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert Kennedy M. D.
Address 1934 W Mosher Av Date signed 1/4/46

X

G35976

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1313

Registered No. G35976

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5318 Dennmore Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Epps

3 (b) If veteran, name war: —

3 (c) Social Security Account No. —

4. Sex: Male | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Marjorie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/16/1906

8. AGE: Years 39 | Months 10 | Days 16 | If less than one day ... hr. ... min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Henry Epps
13. Birthplace Va.

MOTHER
14. Maiden Name Martha White
15. Birthplace Va.

16 (a) Informant Marjorie Epps
(b) Address 5318 Dennmore Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/6/46 (month) (day) (year)
(c) Cemetery or crematory Cumberland
Location Cumberland, Va

18 (a) Funeral director Geo. B. Kelso
(b) Address 1303 Pennsylvania Ave

19 (a) ... (b) Huntington Williams

JAN 4 1946

VS. 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 2 1946 at 2:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 2 1946 to Jan 2 1946 and that I last saw him alive on Jan 2 1946

Immediate cause of death	Duration
Coronary Occlusion	9 days
Pulmonary Embolism	Immediate
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Marked Coronary A's Pulmonary TEC

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Truman D Stephens M. D.
Address Johns Hopkins Hosp. Date signed 1-2-46

94a

635977

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. 635977

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 630 E. 28 St
(c) Hospital or institution: 9-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 630 E 28 St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James H. Mitchell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Col	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 1-1905

8. AGE: Years	Months	Days	If less than one day
40	4	1	hr. min.

9. Birthplace Ala (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Anderson Mitchell
13. Birthplace Ala

MOTHER 14. Maiden Name Amandy Bennett
15. Birthplace Ala

16 (a) Informant Anderson Mitchell
(b) Address 2800 Reese St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-6-46 (month) (day) (year)
(c) Cemetery or crematory Mt Calvery
Location D. D. Co.

18 (a) Funeral director Rayner Sanders
(b) Address 1712 E. Preston

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

JAN - 4 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 2 1946, at 9 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 25 1945 to Jan 2 1945, and that I last saw h alive on Jan 2 1945

Immediate cause of death

(a) Lobar Pneumonia — Duration 9 days

Due to

(b) Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis A. Schuman M. D.
Address 2029 Guilford Ave Date signed Jan 2 1945

G35978

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46

Registered No. G35978

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2614 E. Preston St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2614 E. Preston St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Henry C. Baker.

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W	W

6 (b) Name of husband or wife Barbara G. Fladung
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 13, 1865

8. AGE: Years	Months	Days	If less than one day
80	9	18.	hr. min.

9. Birthplace Maryland. (Town, county, and state)
10. Usual Occupation Car Repairman.
11. Industry or business B. & O. R.R.

FATHER
12. Name Henry Baker.
13. Birthplace Ger.

MOTHER
14. Maiden Name Adelaide Ripson
15. Birthplace Md.

16 (a) Informant Family
(b) Address 2614 E. Preston St.

17 (a) (Burial, cremation, or removal) (b) Date thereof 1-5-46 (month) (day) (year)
(c) Cemetery or crematory Holy Rood. Location Belair Road.

18 (a) Funeral director L. H. Early
(b) Address 130 E. Fort Ave.

JAN 4 1946 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 1 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 17 1945 to Jan 1 1946. and that I last saw him alive on Jan 1 1946.

Immediate cause of death	Duration
Uraemia	1 day
Due to Chronic Myocarditis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Fred Ryals M.D.
Address 1500 Nathan Ave. Date signed 1-4-46

G35979

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. G35979

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2812 Maisel Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days) 52 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2812 Maisel Street (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Wilhelm Frederick Elberskirch

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Anna Marie
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) January 16, 1862

8. AGE: Years 83 | Months 11 | Days 16 | If less than one day: hr. min.

9. Birthplace: Germany (Town, county, and state)
10. Usual Occupation: Retired
11. Industry or business:

FATHER
12. Name: Unknown
13. Birthplace: Germany

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Germany

16 (a) Informant: Emil Elberskirch
(b) Address: 2110 Wilhelm St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-5-46 (Month) (day) (year)
(c) Cemetery or crematory: New Cathedral
Location: Baltimore, Md.

18 (a) Funeral director: George L. Schwartz
(b) Address: 2101 Frederick Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 3, 1946, at 8:25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 21 1945, to Jan 3 1946, and that I last saw h[im] alive on Jan 3 1946.

Immediate cause of death: Pneumonia 1 hour
Due to:
Due to: Arteriosclerosis
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

Duration: 1 hour; 54 yrs.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:
23. Signature: Paul Schaefer
Address: 1 Campbell Date signed 1/5/46

635980

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

635980 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution: Maryland General 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 Dys.
(e) Length of stay in Baltimore (yrs., mos., or days) 77 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1006 E. 20th St.
(If rural give location)
(e) Citizen of foreign country? ------ (Yes or No)
If yes, name country ------

3 (a) FULL NAME Frances T. Gaeng

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife ------

6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) ------

8. AGE: Years 77 | Months --- | Days -- | If less than one day -- hr. --- min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation None

11. Industry or business ------

FATHER
12. Name Michael Gaeng
13. Birthplace Germany

MOTHER
14. Maiden Name Gertrude Schilling
15. Birthplace Germany

16 (a) Informant Mrs. Anna M. Horn
(b) Address 1006 E. 20th Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/7/46 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director H. W. Mears and Son
(b) Address 805 N. Calvert Street

19 JAN -4 1946 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/3 1946, at 9 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/20 1945 to 1/3 1946, and that I last saw her alive on 1/2 1946

Immediate cause of death	Duration
Bronchopneumonia	
Due to	
Due to	
Other Conditions Arterio sclerosis C.V. Disease	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Martin E. Strobel M. D.
Address Md. Genl. Hospital Date signed 1/3/46

635981

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

635981 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BACKS RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 da.
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 634 Wildwood Pkwy.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country Austria

3 (a) FULL NAME Mrs. Mary Schneider

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	widowed

6 (b) Name of husband or wife Andreas Schneider
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 13, 1860

8. AGE: Years	Months	Days	If less than one day
85	4	16	hr. min.

9. Birthplace Austria
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Christian Lorenz
13. Birthplace Austria

MOTHER
14. Maiden Name Mary ?
15. Birthplace Austria

16 (a) Informant Anna Schneider
(b) Address 634 Wildwood P'kway

17 (a) Burial (b) Date thereof 1-7-46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Leonard J. Rusk
(b) Address 5305 Harford Road

JAN - 4 1946
(Date rec'd by registrar) (b) Huntingdon Williamsport

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-3 1946 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-2 1945 to 1-3 1946 and that I last saw h e alive on 1-3 1945

Immediate cause of death: cerebral vascular accident
Due to: diabetes mellitus
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operations:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Crawford W. Kilpatrick Jr. M. D.
Address Union Memorial Hosp. Date signed 1-3-46

VS 150

(over)

X

G35982

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 D

Register's No. G35982

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland D.O.A
(b) Street address 1404 N. Eden St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1404 N. Eden St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

2. (a) NAME (Charles A. Greer) (Charles Greer)
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex M
5. Color or race C
6 (a) Single, married, widowed, or divorced Widowed
6 (b) Name of husband or wife Sarah
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept. 1871
8. AGE: Years 74 Months 3 Days If less than one day hr. min.
9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Laborer (Unemployed)
11. Industry or business
FATHER 12. Name Unknown
13. Birthplace "
MOTHER 14. Maiden Name Emiline —
15. Birthplace Baltimore, Md.
16 (a) Informant Robert Greer (Son)
(b) Address 443 Round View Road.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan. 4, 1946 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location
18 (a) Funeral director Robert H. Young
(b) Address 4 W. Caroline St
19 JAN 4 1946 (Date rec'd by registrar) (Funeral Director) Williams St Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/31 1945, at 12:30 M

21. I certify that I took charge of the remains described above, held an Inspection - Inquest and from the evidence obtained thereon (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C.V. disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D. Medical Examiner
Date signed 1/3/45

VS 151

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35983

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131 A

Registered No. 635983

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2533 Mcculloh St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2533 Mcculloh St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Marguerite B Selden

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Married

6 (b) Name of husband or wife Robert

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-10-1905

8. AGE: Years	Months	Days	If less than one day
40	9	20	hr. min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation Principal (retired)

11. Industry or business public schools

FATHER
12. Name Charles Preston
13. Birthplace Va

MOTHER
14. Maiden Name Christine Allen
15. Birthplace Va

16 (a) Informant Robert Selden
(b) Address 2533 Mcculloh St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/4/46 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk
Location Balto. Co. Md

18 (a) Funeral director Mrs Geo. H. Holland
(b) Address 1631 Druid Hill Av.

19 (a) (Date received by Registrar) (b) Huntington Williams, M.D.

JAN 4 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 12/30 1945 at 11.20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/17 1943 to 12/30 1945, and that I last saw h.e.r alive on 12/24 1945.

Immediate cause of death: Hypertensive cardio-renal disease — Duration 2 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Rayner Browne

Address 1570 E. Madison St Date signed 1/2/46

635984

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. 635984

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1812 West. Lombard Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) ***
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1812 West Lombard Street
(Unnumbered)
(e) Citizen of foreign country? ********** (Yes or No)
If yes, name country

3 (a) FULL NAME RAYMOND B. BISHOP

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-14-1176

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Catherine M.
6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) 2-11-1892

8. AGE: Years	Months	Days	If less than one day
53	10	19	*********\

G35985

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

892

Registered No. G35985

MARGIN RESERVED FOR BINDING

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Reisterstown & Greenspring Ave
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Towson
(If outside city or town limits, write RURAL and give town)
(d) Street No. Proctor Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Minnie Weber (Minnie S. Weber)

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. widowed

6 (b) Name of husband or wife Jacob F. Weber

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 19, 1881

8. AGE: Years 64 | Months 0 | Days 14 | If less than one day hr. min.

9. Birthplace Balto. Co., Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name William Class
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Dumer
15. Birthplace Germany

16 (a) Informant Mr. Carl Weber
(b) Address 7820 Old Harford Rd.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof Jan. 7, 1946 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto., Md.

18 (a) Funeral director Leasaker Funeral Home
(b) Address 7401 Belair Road

19 (Signature and address of registrar) JAN - 4 1946 Registrar
Huntington Williams, M.D.

MEDICAL CERTIFICATION 46

20. DATE OF DEATH Jan. 3, 1946 at 11:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 31, 1945, to Jan. 3 1946 and that I last saw her alive on Jan. 3 1946

Immediate cause of death	Duration
(a) Cerebral embolism	
Due to (b) Arteriosclerosis	
Due to (c)	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operations:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address University Hosp. Date signed 1/2/46

VS 150

G35986 — BALTIMORE CITY HEALTH DEPARTMENT — G35986

CERTIFICATE OF DEATH 108

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 929 N. Castle St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 929 N. Castle St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME George W. Smith.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mary E. Smith
6 (c) If alive, give age 6 years

7. Birth date of deceased (mo., day, yr.) November 23, 1886

8. AGE: Years 60 | Months 1 | Days 11 10 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Night Watchman

11. Industry or business Gibbs Company

FATHER — 12. Name Thomas Smith
13. Birthplace Baltimore, Md

MOTHER — 14. Maiden Name Mary E. Dallahunt
15. Birthplace Baltimore, Md

16 (a) Informant Mary E. Smith
(b) Address 929 N. Castle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/7/46 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location St. Clair & Milton Ave.

18 (a) Funeral director Howard M. Blight, Jr.
(b) Address 4914 Belair Road

19 (a) 1946 (Filed by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/3 1946, at 6 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 12/30 1945 to 1/3 1946, and that I last saw her alive on 1/3 1946.

Immediate cause of death: (a) Flu
(b) Pneumonia

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Hyman Gelber M. D.
Address 5703 Harford Rd. Date signed 1/4/46

X

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35987

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

G35987 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1657 W. North Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME DAVID LEWIS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: White

5. Color or race: Male

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1897

8. AGE: Years 49 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1-7-46 (month) (day) (year)

(c) Cemetery or crematory ?
Location Winston Salem, N.C.

18 (a) Funeral director Oder Bros.
(b) Address 4644 York Rd

19 (a) Huntington Williams, M.D. Registrar
(Filled in by registrar)

A 1956
VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-4-46 19 46 at 8 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Contusion of brain
Pulmonary edema, marked.
Due to

Other Conditions Fracture of left leg.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-2-46 about 11 P. M.
(b) Where did injury occur? 1657 W. North ave
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Fall from Porch.

23. Signature Benedict Skotardis M.D. Medical Examiner.
Date signed 1-4-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35988

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G35988 Registered No. 326

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4015 W. Fayette St
(c) Hospital or institution: Bon Secours
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 da
(e) Length of stay in Baltimore (yrs., mos., or days) all sayo

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street Address Charles & 31st St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Miss C. Ida ROSSITER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1869

8. AGE: Years 77 | Months | Days | If less than one day hr. min.

9. Birthplace Hasbo. Md. (Town, county, and state)

10. Usual Occupation Seamstress

11. Industry or business

FATHER
12. Name Lawrence Roogiter
13. Birthplace Ireland

MOTHER
14. Maiden Name Julia Doyle
15. Birthplace Ireland

16 (a) Informant Bon Secours
(b) Address 4015 W. Fayette St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/5/46 (month) (day) (year)

(c) Cemetery or crematory Catholic
Location Old Frederick Rd

18 (a) Funeral director Chas. Sexton & Son
(b) Address 1300 Eutaw St

19 (a) (Date rec'd by registrar) (b) Registrar

JAN -4 1946 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/3/1946, at 2:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12/20/1945 to 1/3/1946, and that I last saw her alive on 1/2/1946.

Immediate cause of death	Duration
Uremia	3 days.
Due to Nephritis	
Due to Ca. Breast, fungus	
Other Conditions 2nd Anemia & Malnutrition (Include pregnancy within 3 months of death)	

Date of operation none
Major findings of operation: none
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas. Sexton, Jr.
Address Bon Secours Hosp. Date signed 1/3/46 M. D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35939

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1312

G35939
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 709 W. Monument St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days) 49 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 709 W. Monument St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Georgie A. Downs.

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Col	Widow

6 (b) Name of husband or wife Richard Downs
6 (c) ~~If alive, give age~~ ~~years~~

7. Birth date of deceased (mo., day, yr.) Apr 12 1896

8. AGE: Years	Months	Days	If less than one day
49	8	00	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Maid
11. Industry or business Restaurant

FATHER
12. Name Eddie Howard
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Annie Watkins
15. Birthplace Salem Md

16 (a) Informant Annie Barrell
(b) Address 609 W. Watson Lane

17 (a) Burial (b) Date thereof Jan 5 1946
(Burial, cremation, or removal) (Month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore, Md.

18 (a) Funeral director Wm. Francis P. Hennessy
(b) Address 578 W. Baltimore St

19 (a) (b)
(Date received by registrar) Registrar

JAN - 4 1946 Huntington Millmore, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 2 1946 at 9 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 21 1945 to Jan 2 1946, and that I last saw h alive on Jan 2 1946.

Immediate cause of death	Duration
Uraemia	3 days
Due to Hypertension	
Chronic nephritis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 1 W Lee Date signed 1/3/46.

G35990 BALTIMORE CITY HEALTH DEPARTMENT ✓ G35990
Registered No.

CERTIFICATE OF DEATH 93D

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 710 Chestnut Hill Ave.
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 77yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 710 Chestnut Hill Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Frances Heen

3 (b) If veteran, name war —

3 (c) Social Security Account No. None

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband ~~or wife~~ Chas. C. Heen

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan 1 1869

8. AGE: Years 77 | Months 0 | Days 2 | If less than one day hr. min.

9. Birthplace Salisbury Md.
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Solomon R. Corkran
13. Birthplace Dorchester Co. Md.

MOTHER
14. Maiden Name Mary E. Andrew
15. Birthplace Md.

16 (a) Informant Mrs. Joseph H. Schmidt
(b) Address 710 Chestnut Hill ave.

17 (a) Burial (b) Date thereof Jan. 6 1946
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Concord
Location Carolina Co. Md.

18 (a) Funeral director Jerome D. Frampton
(b) Address Federalsburg Md.

19 (a) (Date rec'd by registrar) (b) Washington Williams, Registrar

JAN 4 1946

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 3 1946, at 11.05 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1 Dec 1945 to 3 Jan 1946 and that I last saw h~~e~~er alive on 2 Jan 1946

Immediate cause of death	Duration
Myocarditis	2 yrs
Due to Pneumonia, Bronchial	1 mo.
Due to Arterio-sclerosis	5 yrs.
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas Hooper M. D.
Address 3537 Eberle Ave Date signed 3 Jan 46

G35991

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

G35991 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley Street Baltimore
(c) Hospital or institution:
Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) Five
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country Ireland

3 (a) FULL NAME Elizabeth Mc Knight

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	widowed

6 (b) Name of husband or wife John M. Knight
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 29, 1857

8. AGE: Years	Months	Days	If less than one day
88	3	4	hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation Dressmaker
11. Industry or business

FATHER
12. Name Patrick Mc Grath
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Hyland
15. Birthplace Ireland

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley Street City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 5, 1946 (month) (day) (year)
(c) Cemetery or crematory St Joseph's
Location Govans, Md.

18 (a) Funeral director Rita Wendfeld
(b) Address 914 Greenmount Ave
(c) JAN 4 1946 (Date received by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 3 — 1946, at 4:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 — 1946, to Jan 3 — 1946, and that I last saw her alive on Jan 2 1946

Immediate cause of death — Duration

Edema Lungs — 1 day
Due to Mitral Stenosis — 5 yrs
Due to
Other Conditions Arterio-Sclerosis — 10 yrs

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. Gill Hall M. D.
Address 1631 E North av Date signed 1/3/46

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35992 ✓ G35992

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 938

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Joseph's
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 56 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3520 N. Hilton Road
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGIA DEIBEL

3 (b) If veteran, name war: No
3 (c) Social Security Account No. 220-09-5178

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife August Deibel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 3, 1879

8. AGE: Years 66 | Months 11 | Days 0 | If less than one day ... hr. ... min.

9. Birthplace Manassas, Virginia (Town, county, and state)
10. Usual Occupation Practical Nurse
11. Industry or business

FATHER
12. Name Charles T. Keys
13. Birthplace Manassas, Virginia

MOTHER
14. Maiden Name Regine Cooper
15. Birthplace Manassas, Virginia

16 (a) Informant Mrs. Bessie Cleffler
(b) Address 307 S. Franklintown Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 7, 45 (month) (day) (year)
(c) Cemetery or crematory Govans Presbyterian
Location Bellona Avenue

18 (a) Funeral director Walter Brooks Bradley
(b) Address 1922 N. North Avenue

19 (a) ... (b) ...
(Rec'd by registrar) Registrar

JAN 4 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-3- 1946 at 2 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-29 1945 to 1-3 1946, and that I last saw her alive on 1-3 1946.

Immediate cause of death: Cardio Respiratory Failure — Duration

Due to Myocardial Damage

Due to arteriosclerotic CVD

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M E Robertson M. D.
Address St Josephs Hosp Date signed 1-8 46

Huntington Williams, M.D.

X

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G35993

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

G35993 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Pk. Drive & 31st St.
(c) Hospital or institution:
U.S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Somerset
(c) City or town Crisfield
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Poleyette, Maggie Jane

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Harry Poleyette
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 19, 1896

8. AGE: Years 49 | Months 5 | Days 15 | If less than one day hr. min.

9. Birthplace Crisfield, Md.
(Town, county, and state)
10. Usual Occupation Hwf
11. Industry or business

FATHER
12. Name John T. Tyler
13. Birthplace Md.

MOTHER
14. Maiden Name Nancy Tyler
15. Birthplace Md.

16 (a) Informant Records
(b) Address US Marine Hospital, Balto, Md.

17 (a) Burial (b) Date thereof 1/7/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Crisfield, Md.
18 (a) Funeral director BRADSHAW FUNERAL HOME
(b) Address Crisfield, Md.
19 (a) 1946 (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 3 1946, at 4:35P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 30 1945, to Jan. 3 1946 and that I last saw her alive on Jan. 3 1946

	Duration
Immediate cause of death Carcinoma of ovary with	8 mos
metastasis to lungs	2 mos
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John L. Wilson, Sr. Surgeon M. D.
Address Clinical Director Date signed 1/3/46

VS 150

G35994 BALTIMORE CITY HEALTH DEPARTMENT G35994

CERTIFICATE OF DEATH 93D

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. FOR BIND-

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1121 N. Fulton Ave Dept
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1121 N. Fulton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SARAH ELIZABETH PARLETT

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	widow

6 (b) Name of husband or wife William M. Parlett
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 16, 1877

8. AGE: Years	Months	Days	If less than one day
68	2	17	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Packer
11. Industry or business Martha Wash. Candy Co.

FATHER
12. Name William Bailey
13. Birthplace Unknown

MOTHER
14. Maiden Name Martha Ebaugh
15. Birthplace Unknown

16 (a) Informant Mrs. Elsye Billingsley
(b) Address 1121 N. Fulton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/5/46 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

(a) JAN 4 1946 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/3 1946 at 9 40 A.M.

21. I certify that I took charge of the remains described above, held an Inspection-Inquest thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [signature] M.D.
Medical Examiner.
Date signed 1/6/46

G35995 CERTIFICATE CORRECTED 3-16-49 G35995

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164E

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. OR BIND

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 15 SP

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4104 Penhurst Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Capt. Elmer M. Bryan

3 (b) If veteran, name war: World War #2

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 10, 1915

8. AGE: Years 30 | Months 9 | Days 22 | If less than one day hr. min.

9. Birthplace Pittsburgh, Pa. (Town, county, and state)

10. Usual Occupation Capt.

11. Industry or business U. S. Army

FATHER
12. Name Silas McClure Bryan
13. Birthplace Pittsburgh, Pa.

MOTHER
14. Maiden Name Clara A. Phoebus
15. Birthplace Frederick Co., Md.

16 (a) Informant Mr. Raymond A. Phoebus
(b) Address 4104 Penhurst Ave. 15

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/5/46 (month) (day) (year)
(c) Cemetery or crematory Baltimore National Cem
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) JAN-4 1946 (Date rec'd by registrar) (b) Livingston Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 2 1946 at 2:20 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Ruptured Aorta
Skull Fracture
Due to Crushed Chest
Fracture of all extremities

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Jan. 2 at 2 (1945) 1946 2 P.M.
(b) Where did injury occur? 3rd Baltimore Hotel
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury Jumped from window,

23. Signature Benedict Skaradic M.D. Medical Examiner.
Date signed Jan 3, 1946

G35996 — CHK-94426

BALTIMORE CITY HEALTH DEPARTMENT ✓ 94a

CERTIFICATE OF DEATH

Registered No. G35996

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days) 45 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County 3
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2431 Guilford Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lewin J. Heathcote

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Ella (E.) Heathcote
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 16-1871

8. AGE: Years	Months	Days	If less than one day
74	10	15	hr. min.

9. Birthplace Maryland (Baltimore Co.)
(Town, county, and state)
10. Usual Occupation Retired - Us S. Customs
11. Industry or business Inspector

FATHER
12. Name Martin Heathcote
13. Birthplace England

MOTHER
14. Maiden Name Elis Koller
15. Birthplace Ohio

16 (a) Informant Records-Balto. City Hospitals
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof 1/7/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) 1946 (b)
(Date rec'd by registrar) Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH January 3 1946, at 8:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 28 1945, to Jan. 3 1946, and that I last saw h. alive on Jan. 3 1945

Immediate cause of death	Duration
Coronary occlusion	
Due to	
Due to	
Other Conditions Parkinsonism	2 years

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. Woodward M. D.
Address Baltimore City Hospitals Date signed 1-3-46

X

G35997

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G35997 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Charles & Monument Sts.
(c) Hospital or institution:
Washington Apts.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Washington Apts., Chas. & Monument
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GRETCHEN LOUISE HYDE

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Henry H. Hyde
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 24, 1873

8. AGE: Years	Months	Days	If less than one day
72	8	8	hr. min.

9. Birthplace Saginaw, Mich. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Thomas Nelson Smith
13. Birthplace Canada

MOTHER
14. Maiden Name Gertrude ???
15. Birthplace Michigan

16 (a) Informant Mr. H. H. Hyde
(b) Address Charles & Monument Sts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 1/5/46 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) 1-4 1946 (Date received by registrar) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 2, 1946, at 10:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 20 1945, to June 2 1946 and that I last saw her alive on Jan 2 1946.

Immediate cause of death	Duration
Coronary Occlusion	13 days
Due to Coronary arteriosclerosis	?
Due to	
Other Conditions Hypertension	?

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury —
23. Signature Francis W. Huck
Address 115 Park Ave Date signed 1/4/46

VS 150

Make out in duplicate. Physicians: please write the cause of death correctly. Age is especially important.

G35998

CWK-92467

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 B

Registered No. G35998

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Avenue

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9- 24-

(e) Length of stay in Baltimore (yrs., mos., or days) 22 Yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 2918 Llewellyn Avenue
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Annie Ruth Coles

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 1-1921

8. AGE: Years	Months	Days	If less than one day
24	4	1	hr. min.

9. Birthplace South Carolina
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name Richard Coles

FATHER — 13. Birthplace Virginia

MOTHER — 14. Maiden Name Mary Tinsey

MOTHER — 15. Birthplace South Caroline

16 (a) Informant Records-Balto. City Hospitals

(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof [illegible]-5-1946
(month) (day) (year)

(c) Cemetery or crematory Mt Calvary Cemetery

Location Ox Rd. Md.

18 (a) Funeral director Robert Williams

(b) Address 1515 McCulloh St

19 (a) Date received JAN 4 1946 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 2- 1946, at 1:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 8 1945, to Jan. 2 1945, and that I last saw her alive on Jan. 2 1945.

Immediate cause of death	Duration
Pulmonary Tuberculosis	2
Due to Tuberculosis & enteritis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Lawrence

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Herbert B. Copeland Jr. M.D.

Address Balt. City Hosp. Date signed 1/3/46

VS 150

PLEASE WRITE PLAINLY. Physicians: please write the causes of death clearly and correct age is especially important.

G35999

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160a

G35999 Registered No.

PLEASE WRITE PLAINLY, with ink. Use no abbreviations. Fill in all blanks. Be sure and write the causes of death clearly and legibly. Give exact residence and correct age is especially important. Physicians: please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division st
(c) Hospital or institution:
Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 537 South Paca (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jeanette Anderson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced:

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days: 1 | If less than one day: hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Otis Anderson
13. Birthplace Spartanburg S. C.

MOTHER 14. Maiden Name Jane ?
15. Birthplace South Carolina

16 (a) Informant Otis Anderson
(b) Address 537 S. Paca St.

17 (a) (Burial, cremation, or removal) (b) Date thereof 1 (month) 4 (day) 1946 (year)

(c) Cemetery or crematory Mt. Calvary Cemty
Location Baltimore Md

18 (a) Funeral director Walter B. Long
(b) Address 139 N. Hanover St.

1946 JAN - 4 (Date rec'd by registrar) Registrar for Williams Mar

MEDICAL CERTIFICATION 46

20. DATE OF DEATH 1-2-46 1945 at 10:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1-1 1945 to 1-2 1945, and that I last saw her alive on 1-2 1945

Immediate cause of death Secondary Anemia — Duration 4 days (Estimated)

Due to Hymanhoge from Cond.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(c) Means of injury

23. Signature W. F. Howell

Address 601 N Carrollton Ave Date signed 1-3-46 M D

VS 150

636000

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

636000 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2100 E. Federal St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2100 E. Federal St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lurenora S. Stewart

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 30th 1874

8. AGE: Years 71 | Months - | Days 3 | If less than one day hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Royston Marsh
13. Birthplace Va.

MOTHER
14. Maiden Name —
15. Birthplace Va

16 (a) Informant Mrs Ralph Stewart
(b) Address Brooklyn Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 7th 1946 (month) (day) (year)
(c) Cemetery Loudon Park
Location Fredrick Road

18 (a) Funeral director Leo. G. Leach
(b) Address 1701-03 N. Patterson Park Ave

19 (a) Huntington Williams Registrar
(Date received by registrar) JAN - 4 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 2nd 1946 at 9:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1 1945 to Jan 2 1946
and that I last saw h[illegible] alive on Jan 2 1946.

Immediate cause of death: (a) Cardiac Failure — Duration 1 Hr.

Due to: (b) Coronary Thrombosis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]

Address 5402 Belair Rd Date signed 1-4-46

Dr Brosfeld 5402 Belair Rd

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be answered. Where none, write none. Do not use ditto marks. Be sure to write the causes of death clearly and legibly. Correct age is especially important. Physicians: please write your names plainly.

CITY HALL
BALTIMORE 2 MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE

RECORDS MANAGEMENT DIVISION

CERTIFICATION

THIS IS TO CERTIFY THAT ON THIS 8/15 DAY OF 1963 THE MICROPHOTOGRAPHS APPEARING HEREIN STARTING WITH 33480 AND ENDING WITH 36000 ARE ACCURATE AND COMPLETE REPRODUCTIONS OF THE RECORDS OF THE DEPARTMENT OF Health BUREAU OF Vital Statistics AS DELIVERED IN THE REGULAR COURSE OF BUSINESS FOR PHOTOGRAPHING, AND THAT:

TO THE BEST OF MY KNOWLEDGE THE MICROFILM MEETS THE REQUIREMENTS OF THE NATIONAL BUREAU OF STANDARDS FOR PERMANENT MICROPHOTOGRAPHIC COPY.

CAMERA OPERATOR: Loretta Byrne



END OF REEL